ANCHORPOINT
COUNSELING MINISTRY

Congratulations on beginning the counseling process. Included in this packet are some general questions and a couple of inventories to help your therapist begin to get to know you and your reasons for attending therapy. Brief answers are okay; you can discuss any further information with your therapist during your first session.

Date: Client Name: Date of Birth:

Person completing survey and relationship to client:

Address:

Phone: Email Address:

I give permission for Anchorpoint to leave a voicemail regarding your treatment: Yes/No

I give permission for Anchorpoint to email me regarding my treatment: Yes/No

What is your current marital status?

What is your gender?

In a couple of sentences, please describe your situation and your goals for therapy.

Briefly, how would you describe the history of these difficulties.

FAMILY INFORMATION

Who are the other adults in your home? Please include age, gender, occupation (if applicable), and your relationship to each individual.

Who are the children in your home? Please include age, gender, school grade, and your relationship to each individual.

Briefly describe what you see as the main strengths of your family.

Please include information regarding any mental health difficulties for members of your immediate and extended family. Examples include depression, anxiety, alcoholism, drug abuse, anger, etc.

Relationship to client	Age	Mental health difficulty	Age of onset	Severity of difficulty

EMOTIONAL AND PSYCHOLOGICAL INFORMATION

Patient Health Questionnaire (PHQ)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	○	○	○	○
2. Feeling down, depressed, or hopeless	○	○	○	○
3. Trouble falling or staying asleep, or sleeping too much	○	○	○	○
4. Feeling tired or having little energy	○	○	○	○
5. Poor appetite or overeating	○	○	○	○
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	○	○	○	○
7. Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
8. Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	○	○	○	○
9. Thoughts that you would be better off dead, or of hurting yourself in some way	○	○	○	○

Have you ever been hospitalized for mental health difficulties? If so, when and what were the reasons and outcomes?

Have you ever attempted suicide? If so, when and what were the reasons?

Have you had any history of violent behavior? If so, when and what were the circumstances?

Are you currently taking any medications for:

A. Medical reasons?
B. Psychological reasons?
C. In the past have you taken medications for physical or emotional problems?

GAD-7

Please read each statement and select a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past two weeks. There are no right or wrong answers. Do not spend too much time on any one statement. This assessment is not intended to be a diagnosis. If you are concerned about your results in any way, please speak with a qualified health professional.

	0: Not at all	1: Several days	2: More than half the days	3: Nearly every day
Feeling nervous, anxious or on edge	○	○	○	○
Not being able to stop or control worrying	○	○	○	○
Worrying too much about different things	○	○	○	○
Trouble relaxing	○	○	○	○
Being so restless that it is hard to sit still	○	○	○	○
Becoming easily annoyed or irritable	◉	○	○	○
Feeling afraid as if something awful might happen	○	○	○	○

Have you attended therapy before? If so, when and for what reasons? What were the outcomes?

SUBSTANCE ABUSE HISTORY

Do you have a history of any recreational drug use?

- ○ Yes
- ○ No

If YES, please fill out the table below to the best of your knowledge:

SUBSTANCE(S) USED:	YES	NO	AGE OF FIRST USE	AGE OF LAST USE	USAGE AMOUNT (SOCIAL, LIGHT DAILY, MED. DAILY, HEAVY DAILY)
TOBACCO	☐	☐			
ALCOHOL	☐	☐			
AMPHETAMINES/SPEED	☐	☐			
BARBITURATES/DOWNERS	☐	☐			
OPIATES	☐	☐			
COCAINE	☐	☐			
PSYCHEDELICS	☐	☐			
INHALANTS	☐	☐			
MARIJUANA	☐	☐			
BENZODIAZEPINES	☐	☐			
PCP	☐	☐			
OTHER:	☐	☐			
OTHER:	☐	☐			

HEALTH AND DEVELOPMENTAL HISTORY

During your pregnancy/birth, did your mother have problems with any of the following:

- ☐ None of these
- ☐ Exposure to drugs or alcohol during pregnancy
- ☐ A difficult pregnancy
- ☐ Problems with delivery

Were there any complications after your birth? (e.g. premature birth, jaundice, breathing difficulties)

Did you have any delays or difficulties in reaching the following developmental milestones?

- ☐ None of these
- ☐ Walking
- ☐ Talking
- ☐ Toilet training
- ☐ Sleeping alone
- ☐ Being away from parents
- ☐ Making friends

Other:

Which options below best describe your childhood home atmosphere?

- ☐ Normal
- ☐ Supportive
- ☐ Parental fighting
- ☐ Parental violence
- ☐ Financial difficulties
- ☐ Frequent moving

Which of the following challenges were experienced during your childhood?

- ☐ None of these
- ☐ Tantrums
- ☐ Enuresis (bed wetting)
- ☐ Encopresis (fecal incontinence)
- ☐ Running away from home
- ☐ Fighting
- ☐ Stealing
- ☐ Property damage
- ☐ Fire setting
- ☐ Animal cruelty
- ☐ Separation anxiety
- ☐ Victim of bullying
- ☐ Engaged in bullying
- ☐ Depression
- ☐ Death of a parent/caregiver
- ☐ Parental divorce

Which of the following best describe problems you may have had in school?

- ☐ None of these
- ☐ Fighting
- ☐ School phobia
- ☐ Truancy
- ☐ Detentions
- ☐ Suspensions
- ☐ Expulsions
- ☐ School refusal
- ☐ Class failures
- ☐ Repetition of grades
- ☐ Special education
- ☐ Remedial classes

Highest level of education attained:

SOCIAL AND SPIRITUAL

Which options below best describes your social situation?

- ☐ Supportive social network
- ☐ Few friends
- ☐ Substance-use based friends
- ☐ No friends
- ☐ Distant from family of origin
- ☐ Family conflict

How important is spirituality/religion to you (circle)? Very important/Somewhat important/Not important

Would you like spirituality/religious beliefs incorporated into counseling? Yes/No

If yes, what are some of the spiritual or religious resources that nourish your faith?

Please describe what you would like to have happen by participating in counseling at Anchorpoint:

By signing this document, I demonstrate that I understand this information is protected in accordance with the ***Notice of Privacy Practices*** as well as the ***Health Insurance Portability and Accountability Act (HIPAA).***

Client Name:_____

Signature:_____ Date: _____