Client Name: ______________________________ Date: ____________________

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 of Birth:_________________________________

Person completing survey and relationship to client:

____

Street Address: ____ **City:** ____

State: __________________________ **Zip Code:** _________________________

Phone: _____________________________________ **Email Address:** ____

Marital Status: ___________________________________ **Gender Identity:** ______________________________________

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

____

____

____

____

FAMILY INFORMATION

Who are the other adults in your home?

Name: _____________________________________ Age: ________ Relationship: __________________________________

Name: _____________________________________ Age: ________ Relationship: __________________________________

Name: _____________________________________ Age: ________ Relationship: __________________________________

Name: _____________________________________ Age: ________ Relationship: __________________________________

Who are the children in your home?

Name: _____________________________________ Age: ________ Relationship: __________________________________

Name: _____________________________________ Age: ________ Relationship: __________________________________

Name: _____________________________________ Age: ________ Relationship: __________________________________

Name: _____________________________________ Age: ________ Relationship: __________________________________

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

____

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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

Please read each statement and select a number 0 (not at all), 1, 2 or 3 (nearly every day) which indicates how much the statement applied to you over the past two weeks.

Place an "X" in the corresponding box that matches you answer.

Over the last two weeks, how often have you experienced any of the following items?	0 (0 days)	1 (3-6 days)	2 (7-10 days)	3 (10-14 days)
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself—or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
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				
Thoughts of hurting yourself or suicidal ideations				

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 now or have you ever taken any prescription medications to better your mental health? If so, what are they?

____

____

____

GAD-7

Please read each statement and select a number 0 (not at all), 1, 2 or 3 (nearly every day) 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.

Place an "X" in the corresponding box that matches you answer.

	0	**1**	**2**	**3**
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, how long ago? What were the reasons you sought help, and what was the outcome?

____

____

____

____

SUBSTANCE ABUSE HISTORY

Do you have a history of any recreational drug/alcohol 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	FREQUENCY (social, weekly, daily, multiple times per day)
TOBACCO					
ALCOHOL					
AMPHETAMINES/SPEED					
BARBITURATES/DOWNERS					
OPIATES					
COCAINE					
PSYCHEDELICS					
INHALANTS					
MARIJUANA					
BENZODIAZEPINES					
PCP					
OTHER					
OTHER					

HEALTH AND DEVELOPMENTAL HISTORY

Were there any complications before or after your birth?

[ ] Exposure to drugs or alcohol
[ ] Problems with delivery
[ ] Premature birth
[ ] Other___________________________________
[ ] Jaundice
[ ] Breathing difficulties
[ ] Physical or mental disability assigned at birth
[ ] None

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

[ ] Walking
[ ] Talking
[ ] Toilet training
[ ] Sleeping alone
[ ] Being away from parents
[ ] Making friends
[ ] Other____
[ ] None

Which options below best describe your childhood home atmosphere?

[ ] Normal
[ ] Supportive
[ ] Parental Fighting
[ ] Parental Violence
[ ] Financial Difficulties
[ ] Frequent Moving
[ ] Poor Living Conditions

Which of the following challenges were experienced during your childhood?

[ ] Tantrums
[ ] Enuresis (bed wetting)
[ ] Encopresis (fecal incontinence)
[ ] Fighting
[ ] Fire Setting
[ ] Stealing
[ ] Property Damage
[ ] Depression
[ ] Animal Cruelty
[ ] Separation Anxiety
[ ] Running Away from Home
[ ] Parental Divorce
[ ] Victim of Bullying
[ ] Engaged in Bullying
[ ] Death of Parent/Caregiver
[ ] None

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

[ ] Fighting
[ ] School Phobia
[ ] Truancy
[ ] Detentions
[ ] Suspensions
[ ] Repetition of Grades
[ ] Special Education
[ ] School Refusal
[ ] Class Failures
[ ] Expulsions
[ ] Remedial Classes
[ ] None
[ ] Other:____

What is the highest level of education you have achieved?

[ ] Elementary (K-8)
[ ] Associate's Degree
[ ] Master's Degree
[ ] High School/GED
[ ] Bachelor's Degree
[ ] Doctorate Degree

SOCIAL AND SPIRITUAL

Which options below best describes your social situation?

[ ] Supportive Social Network
[ ] No friends
[ ] Few Friends
[ ] Distant from Family of Origin
[ ] Substance-use based friends
[ ] Family Conflict

How important is spirituality/religion to you?

[ ] Very important
[ ] Somewhat important
[ ] Not important

Would you like spirituality/religious beliefs incorporated into counseling?

[ ] YES
[ ] NO

If yes, in what way do you find you most like to connect with your spirituality?

____

____

____

____

I give permission for Anchorpoint to leave a voicemail regarding my treatment:

[ ] YES **[ ]** NO

I give permission for Anchorpoint to email me regarding my treatment:

[ ] YES **[ ]** NO

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: ______________________