ANCHOR OF HOPE

Thank you for choosing Anchor of Hope Counseling. We look forward to providing services to you.
We appreciate you taking the time to fill out this form completely before beginning services.

BACKGROUND INFORMATION

Name: ______________________ **Date:** ____________

Phone: ( ) ______________________ **Email:** ____________

Address: ______________________

DOB: ______________________ **Race/Ethnicity:** ____________

CURRENT CONCERNS

Please check all the symptoms that apply to you

- ☐ Loss interest in previous hobbies
- ☐ Guilt
- ☐ Decreased Energy
- ☐ Difficulty with concentration
- ☐ Loss of appetite
- ☐ Difficulty with sleeping
- ☐ Thoughts of suicide or self-harm
- ☐ Easily distracted
- ☐ Taking risks
- ☐ Racing thoughts
- ☐ Talkative
- ☐ Little Need for sleep
- ☐ Very active/on the go
- ☐ Feeling overly important
- ☐ Anxiety/worry
- ☐ Panic attacks
- ☐ Avoid going places
- ☐ Avoid being with others
- ☐ Checking things repeatedly
- ☐ Perfectionist
- ☐ Lots of fear
- ☐ Depression
- ☐ Feeling helpless/hopeless
- ☐ Episodes of Crying
- ☐ Moody
- ☐ Feeling Empty Inside
- ☐ People pleasing
- ☐ Anger
- ☐ Stomachaches
- ☐ Headaches
- ☐ Backaches
- ☐ Eating challenges
- ☐ Body image difficulties
- ☐ Sexual difficulties
- ☐ Sexual addictions
- ☐ Concerns with drinking alcohol
- ☐ Concerns with drug use
- ☐ Past alcohol/drug use
- ☐ Recreational drug use
- ☐ Thoughts of hurting others
- ☐ Legal problems
- ☐ Work problems
- ☐ Difficulty remembering
- ☐ Confusion
- ☐ Getting lost more often
- ☐ Difficulty making decisions
- ☐ Feeling suspicious at times
- ☐ Having strange experiences
- ☐ Hearing voices
- ☐ Seeing things
- ☐ Financial problems
- ☐ Learning problems
- ☐ Relationship problems
- ☐ Gambling

What is the primary reason you are seeking counseling services?

____

____

Are there are there any other concerns (not listed) that you want to discuss?

____

____

FAMILY & SUPPORTIVE RELATIONSHIPS

Name	Age	Relationship	Quality of Relationship *(e.g. Good, Fair, Poor)*	Living with you? *(Y/N)*

Marital Status: ☐ Married ☐ Never Married ☐ Divorced ☐ Widowed

EDUCATION & EMPLOYMENT INFORMATION

Highest (or current) Grade Level Achieved: ______________________

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Retired

Current Employer (If applicable): ______________________

TRAUMA HISTORY

Have you ever had a history of trauma, abuse or neglect? ☐ Yes ☐ No

If yes, what type of abuse or trauma occurred?

☐ Physical ☐ Sexual ☐ Emotional ☐ Neglect ☐ Verbal

CURRENT OR PAST MILITARY HISTORY

Are you currently serving or have you served in the military? ☐ Yes ☐ No

If yes, please explain when, how long, & in what branch: ______________________

____

LEGAL SYSTEM

Have you or are you currently involved with the legal system, friend of court, or child protective services? ☐ Yes ☐ No

If yes, please explain: ______________________

MENTAL HEALTH TREATMENT HISTORY

Have you ever received inpatient or outpatient mental health services? ☐ Yes ☐ No

Where	When

MEDICAL INFORMATION

Do you have any current or ongoing medical concerns?

____

____

Please list all current medications and supplements you are taking:
(Attach another page if needed and bring list to next appointment)

Name of Medication	Dosage/Amount	Frequency

SUBSTANCE USE

Do you drink alcohol? ☐ Yes ☐ No
Do you use tobacco? ☐ Yes ☐ No
Do you use drugs? ☐ Yes ☐ No

Has alcohol/drug use interfered with family, work, health, or your interpersonal life? ☐ Yes ☐ No
Have others viewed your use as a problem? ☐ Yes ☐ No
Have you ever tried to cut down or quit? ☐ Yes ☐ No
Have you had prior substance abuse treatment? ☐ Yes ☐ No
If yes, please explain when and where: ______________________________

SPIRITUAL

What is your present religious affiliation if any? ______________________________
Would you like spirituality integrated into treatment? ☐ Yes ☐ No

Patient Signature: ______________________________ **Date:** ____________

Therapist Signature: ______________________________ **Date:** ____________