Beyond Healing **Healing the Mind, Body, & Spirit**

Thank you for choosing Beyond Healing – A Counseling, Wellness, & Personal Growth Center. To make your time here more productive, please assist the professional staff by completing the questionnaire. The questions are designed to provide information for the purpose of knowing you better. The information that you provide will be held in strict confidence. Naturally, we encourage you to take your time and learn from your responses. Please omit any questions that do not apply to you. Thank you for your help.

About You:

Name:_____

Today's Date:_____

Address:_____City:_____State:_____ Zip code:_____

Home Phone:_____ Work Phone:_____ Other:_____

O.K. to leave messages? Yes No How may we identify ourselves? *(GSU Counselor, by name, just GSU or other):*

_____

Referral Source:_____

Best days and times to reach you:_____

Primary Emergency Contact:

Name:_____

Relationship:_____Address:_____

Phone:_____***Demographics:***

Age:_____ Date of Birth: _____/_____/_____ Race:_____ Sex: M F

Religion:_____ Primary Language:_____

Relationship Status:_____

Date of Marriage:_____/_____/_____

Date(s) of previous marriage(s):

From:____/_____/_____ To:_____/_____/_____ How did marriage end?:_____

From:____/_____/_____ To:_____/_____/_____

How did marriage end?:_____Any history of domestic violence? ___Yes ___No

If yes, explain_____Any history of alcohol abuse? ___Yes ___No

If yes, explain_____Any history of drug abuse? ___Yes ___No

If yes, explain_____

Presenting Problem(s): (*state in your own words the reasons for which you are requesting help)*

_____

_____

_____

_____

_____

Please give a brief history of the problem(s):

_____

_____

_____

_____

_____

_____

___

About Your Partner:

Name of Partner:_____ Is your partner employed? Yes NoIf yes, where:_____

What does he/she do?:_____

Do you have any concerns or questions about your partner or marital status that we should be aware of, or that you would like to
discuss?:_____

_____

In two or three words, describe your partner:_____

In two or three words, describe your family:_____

About Your Family Background:

Please list your brothers and sisters and their ages:

Name Age Name Age _____

_____

_____

_____

_____

Is your Father living?_____

Date and Cause of Death:_____

Father's occupation:_____

Is your Mother living?_____ Date and Cause of Death:_____

Mother's occupation:_____

Was there any sexual abuse in the family (if yes, please explain):_____

_____

_____

_____

_____

_____

Was there a history of alcohol/drug abuse within the family? If yes, please explain:_____

_____

_____

_____

_____

_____

Briefly describe the quality or nature or your relationship with your parents and note any questions or concerns you might wish to raise regarding that relationship:_____

_____

_____

_____

About Your Children:

Please list your children and stepchildren:

Name Age Date of Birth Sex Living with you?_____

_____

_____

_____

_____

_____

___

Names and Relationships of other people who currently live with you: **Name Age Relationship How long have they lived with you?**

_____

_____

_____

_____

Child Concerns:

Identify by writing the name(s) of the child (children) in the space next to the concern you or your partner have: Bad dreams:_____ Moods:_____ Health problems:_____

Hyperactivity:_____ Worry:_____

Fighting:_____Fears:_____ Arguing:_____

Jealousy:_____Complaining:_____ Sleep:_____

Depression:_____Unhappiness:_____ Stealing:_____

Immaturity:_____Friendships:_____ Shyness:_____

Sexual Abuse:_____Physical Abuse:_____ Anger:_____

Bed Wetting:_____ Disobedience:_____ Lying:_____

Attentiveness:_____Sexual Concerns:_____ Allergies:_____ Running away:_____ Drug/Alcohol Use:_____ Impulsiveness:_____

School Work:_____Relations with stepchildren:_____

School Performance:_____Visitation arrangements:_____ Interference with ex-partner:_____*Please state briefly any special concerns or questions about your children that you think we should discuss:*

_____

_____

Health Concerns:

List all previous professional help or hospitalizations you have received for personal, marital or family concerns:

Kind of Treatment Date Name of Provider

Reason_____

_____

_____

_____

List any illnesses or disabilities that have affected you or a family member in the past year:

_____Have you ever had thoughts about suicide? ___Yes ___No

Have you ever attempted suicide? ___Yes ___No If so when?_____

Health Issues Checklists:

Please check any of the following which may apply:

___anxiety, tension, nervousness ___ chronic illness___coldness or numbness in fingers ___crying spells

___ chronic pain___drug use ___dizziness or fainting spells ___ diarrhea/constipation

___excessive caffeine use___excessive alcohol use ___excessive medication use

___ excessive appetite___frequent upset stomach/indigestion/nausea ___ frequent wakening/early wakening

___frequent or severe headaches ___heart palpitations or pounding ___high blood pressure/hypertension

___hormonal imbalances (eg. Menopause, PMS) ___infertility ___inability to concentrate

___ lack of appetite ___muscle tension/spasticity/cramps ___memory problems

___ pregnancy___problems falling asleep ___shortness of breath/ rapid breathing

___sexual functioning problem ___stiffness/aching/burning sensation in joints___ urinary problems

Reasons for Seeking Counseling:

___ adoption ___ ambition ___ assertiveness ___ anger with God___bereavement ___criminal behavior ___ confusion

___ couple problems ___ communicating___ depression___ despair ___decision making ___ dating ___ divorce ___ education

___ eating disorder ___ finances___ fears and worries ___ friends ___ gambling ___ guilt ___ gender identity___ inferiority

___ infidelity of self ___ infidelity of partner ___ insecurity___ internet relationships ___ loneliness___ loss of faith in others

___ loss of meaning___ loss of love ___ loss of faith in God ___ legal matters ___ pornography/cybersex___ parenting

___ physical abuse___ premarital concerns ___ self-control ___ sexual abuse ___ sexual concerns ___ sexual identity

___ self-doubt ___ sexual response ___ self-concept ___ shame___ shyness ___ suicidal thoughts ___ separation

___ temper ___ troublesome dreams ____ unhappiness ___ other: _____

*Please put a ***** by the items that are causing you the **most** difficulty **If you are experiencing problems in your relationships***

with others please indicate by circling all that apply:Partner Child/Children Parent(s) Sibling(s)

Extended Family In-Laws Friends Other: _____

Comments:_____

_____

Vocational History:

Place of Employment: _____

Part or Full time:_____Occupation:_____

How long have you had your present job?:_____

Any problems at work?:_____

Highest grade or education degree completed:_____

Any specific problems while you were in school?:_____

Military/Veteran Status: N/A:_____ Dates:_____

Position in service:_____ Stationed:_____

Did you serve in combat?:_____

Comments:_____

Please rate your feelings regarding how hopeful you are that counseling will help: (please check mark your response)

___Very Hopeless ___Somewhat Hopeless ____Unsure ____Somewhat Hopeful ___Very Hopeful

Have you ever seen a therapist, psychologist, psychiatrist, or other mental health professional? Y NIf so, please explain (when, where, reason, results)_____

_____

_____

_____

Comments or concerns about
Counseling:_____
_____
_____
_____

Goals:

What brings you here?_____
_____
_____
_____
_____
_____

What would you like to see different in your life?

_____
_____
_____
_____
_____
_____

What do you believe are your strengths?

1. _____
2. _____

3. _____
4. _____
5. _____

What gets in the way of your success? Areas you need to work on:

_____

_____

_____

_____

___

-End of Questionnaire-