

Has your interest in food increased, decreased, or stayed about the same? _____

Have you gained or lost weight recently? _____

How frequently do you have trouble falling asleep? _____

How frequently do you wake up in the middle of the night and can't go back to sleep? _____

Mental Health:

Do you use cigarettes? _____ alcohol? _____ Illicit drugs? _____ If so, what _____

Frequency of use: _____

Do you have a prior history of addiction or chemical dependency? _____

Did you receive treatment? _____ When? _____ Where? _____

Have you sought professional counseling in the past? _____ When? _____

Name of most recent mental health provider(s) _____

What self-help programs (AA, Al-Anon, NA, grief groups, etc.) have you attended? _____

What other resources for support (friends, family, pastor, etc.) do you have? _____

What do you do to relieve stress? _____

Spiritual Health:

Do you believe in God or a Higher Power? _____

What is your church or religious affiliation, if any? _____

What are your reasons for seeking counseling? _____

Who referred you? _____

Emergency Contact: _____ Phone _____

Information and Guidelines reviewed? Yes _____ No _____ (Please initial) _____

Privacy Policies reviewed? Yes _____ No _____ (Please initial) _____

Signed _____ **Date** _____