WELLNESS COUNSELING CENTER
103 WEST COLLEGE AVENUE • APPLETON, WI 54911
920-733-1992

Today's Date: _____

PERSONAL INFORMATION & INITIAL ASSESSMENT

Name_____Age_____Date of Birth_____Sex:____M____F
Address_____
Home Phone_____Work Phone_____ O.K. to Leave Message At Home?___Work?___
Email Address_____@_____ O.K. to Contact Via Email? _____
Family Physician_____ Referred By _____
Emergency Contact _____ Phone #: _____

CURRENT PROBLEM:

1. Please describe the primary problems for which you are now seeking help. _____
_____
_____
_____

2. When did the problem(s) begin? _____
_____

3. How is the problem affecting your life?
_____
_____

4. What, specifically, would you want from treatment here?
_____
_____
_____

5. What do you see as your personal strengths? _____
_____
_____

FAMILY HISTORY:

1. Marital Status: Married/Partnership _____How Long _____
Separated _____Divorced _____Widowed _____ Engaged _____Single _____

2. List first name, age, and relationship of persons with whom you now live: _____
_____
_____
_____
_____

3. How would you describe your present family? _____
_____
_____

4. Spouse or partner's employment?
_____
_____

5. Does anyone in your household have a significant health problem? Describe: _____
_____

6. Previous Marriages? _____
_____

7. List children not living with you, their age, and location:_____
_____
_____

DEVELOPMENTAL INFORMATION:

1. The family you grew up in: How many siblings?_____ Where are you in order of birth?_____
Anyone adopted?_____ Foster Children?_____
Any parental divorce, separation, death, remarriage?_____Your age at that time?_____
Anything else important about your family?_____
2. Briefly describe any problems during your childhood: (School, Behavior, Health, Family, Emotional)

_____

_____

During Adolescence:_____

EDUCATION:

1. School attending presently:_____ Highest grade completed:_____
2. Post high school education: Where:_____When:_____
Degree or Certification:_____

WORK HISTORY:

1. Present Occupation(s):_____ Hours Per Week:_____
2. Employer(s):_____ How long have you been employed there?_____
3. Does your present work satisfy you?_____ If not, why not?_____

_____

LEGAL:

1. Have you ever been in trouble with the law or had legal problems?_____If so, please describe:_____

_____

HEALTH:

Height_____Weight_____Recent Changes_____Reason_____

1. List any health problems you are currently being treated for:_____

_____

2. Have you ever been hospitalized?_____Reason_____

_____

3. Any significant health problems, accidents, allergies, or injuries?_____If so, please describe:_____

_____

4. What medications (prescription and non-prescription) are you presently taking?_____

_____

5. Please list any past medication(s) given you for emotional problems (anxiety, depression, nervousness)

_____

6. Please list any outpatient treatment you have received for mental health, alcohol, or drug abuse. Include therapist, place of treatment and reason:_____

_____

7. Have any blood relatives (parents, grandparents, aunts, uncles, sisters, brothers, children) had any significant health problems? _____ Include mental health, and alcohol and drug abuse. List person, relationship and problem. _____

_____

RELIGION:

1. In what religious faith/traditions were you raised? _____ Current religion:_____

MILITARY:

1. Have you ever served in the military?_____ Branch of Service:_____ Time in Service:_____
Type of Discharge:_____

ALCOHOL AND DRUG:

1. Do you drink alcoholic beverages?_____If so, describe how much you drink, and what you drink on a daily and weekly basis:_____
2. Do you use any other non-prescription drugs?_____ If so, describe what, how much, and how often:_____

_____

3. Do you smoke?_____ If so, how much and how often:_____

CHECK (√) PROBLEMS

	Current Problems	**Past Problems**
Relationship problems (with whom)		
Loneliness, isolation, shyness		
Lack of confidence		
Effects of loss, stress, trauma, illness		
Trouble controlling:		
Use of alcohol or other drug		
Overeating		
Under eating		
Purging		
Gambling		
Sexual Behavior		
Anger		
Spending		
Other		
Sexual problems, dissatisfactions, identity issues		
Depressed mood		
Rapid mood swings		
Lack of interest or pleasure		
Feeling worthless, guilty, inadequate		
Problems with concentration		
Lack of energy		
Suicidal ideas or pressures		
Agitation		
Irritability		
Racing thoughts		
Diminished need for sleep		
Nightmares		
Insomnia		
Excessive fatigue/sleepiness		
Dizziness		
Headaches		
Problems with digestion/elimination		
Trouble breathing		
Menstrual problems		
Unexplained pain in:		
Anxiety related to:		
Panic attacks		
Persistent worry		
Phobia(s)		
Repeated unwanted thoughts or actions		
Memory loss		
Feeling spacy or detached		
Not feeling safe		
Any important information not covered on this list:		