Counseling Center
20555 Kingsland Blvd.
Katy, Texas 77450
281.492.0785

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License #18563

We are honored by your decision to seek assistance from our Counseling Ministry. This ministry strives to glorify Jesus Christ and to produce sound minds and Christian behavior. The counseling we provide, both pastoral and professional, is guided by principles which are scripturally based and psychologically sound.

Date: ___________

Personal History

Please answer all questions honestly.
The degree of your healing is relevant to the degree of transparency.
All information is confidential.

General Information

Name: ______________________________________ Email: ____
Cell Phone: ______________________________ Work Phone: ____
Address: ____________________________________City:_________________________Zip:____________________
Birth date: ______________ Age: ________

Emergency Contact #1
Name: ____ Relationship: _____________________________________
Home/Cell Phone: ______________________________ Work Phone: _____________________________________

Emergency Contact #2
Name: ____ Relationship: _____________________________________
Home/Cell Phone: ______________________________ Work Phone: _____________________________________

Medical Information

Do you have any medical problems? Yes____No____ Describe:_______________________________________
____
Treating Physician:_______________________Speciality________________Date of Last Physical___________
List any current medication, dosage, and reason (including vitamins/herbs/over the counter medication):____
____

Have you ever been prescribed medication for a psychiatric diagnosis? Yes____ No_____
If yes, list medication (even if you are no longer taking it)____
____
Have you received counseling previously? Yes_____No_____ When, where and reason:_______________
____
Are you currently under the care of a mental health professional (i.e. Psyciatrist, Psychologist, or Counselor)? Yes_____ No______
Do you or your family have any history of depression or other similar mental health problems?
Yes____ No_____ If yes, describe____
____
Have you ever been admitted to a hospital or treated for any psychotherapy or counseling?
____
____
Have you ever had hallucinations? Yes ____ No____ When?_______________________________________
Do you or your family have any history of drug/alcohol abuse? Yes____ No____
If yes, describe____
Is there any history of sexual abuse or physical abuse toward you? Yes____ No____
If yes, describe____
Have you had any recent weight changes? Describe____

Additional Information

Have you recently suffered the loss of someone who was close to you? If yes, please explain:
____
____

Have you recently experienced a significant change or traumatic experience? If yes, please explain:
____
____

Are you able to cope with all of your present circumstances? Please explain:
____
____

If you could change your present circumstances, what would you change?
____
____
How many hours do you sleep at night?____
____
Has there been any recent change in your sexual activity? If so, explain:____________________________
____
Have there been any recent changes in your financial situation? If so, explain:______________________
____
Do you ever feel suicidal? Yes _____ No _____If yes, please explain_____________________________________
____

Have you ever been arrested? Explain____
____
Have you ever experienced a time of such severe emotional turmoil that it affected your ability to complete your normal tasks and responsibilities? Yes_____No_____ If yes, please describe____________
____

Why are you seeking counseling?
____
____

Would you say your problems are more:
_____Physical _____Mental _____Emotional _____Spiritual in nature

Current Symptoms

Check all that apply

____ Anxious thoughts
____ Excessive dieting
____ Excessive eating
____ Compulsive exercising
____ Compulsive sexual behaviors
____ Feelings of hopelessness
____ Disturbance of thought
____ Unusual fears
____ Thoughts of suicide
____ Change in weight
____ Change in sleep
____ Sleep disturbances
____ Hearing voices
____ Change in appetite
____ Change in personal relationships
____ Health problems
____ Increase/decrease in sex drive
____ Panic attacks
____ Anger outbursts
____ Obsessions/Compulsions
____ Hyperactivity
____ Depressed mood
____ Feelings of being overwhelmed
____ Loss of interest in activities
____ Poor memory
____ Daydreaming
____ Forgetfulness
____ Guilt
____ Feelings of helplessness
____ Feeling unloved by others
____ Feeling unloved by God
____ Recurrent distressing dreams
____ Sense of reliving traumatic events
____ Delusions (unreasonable thoughts or beliefs)
____ Do you hear or see things that others don’t
____ Physical abuse (past or current)
____ Sexual abuse (past or current)
____ Psychological abuse (emotional/verbal)
____ Binging/compulsive overeating
____ Intentional vomiting
____ Use of diuretics or laxatives

Marriage and Family Information

Marital Status (circle):
Single Dating Engaged Married Separated Divorced Widowed

Name of spouse: ____________________________________ Occupation: ______________________________________
Spouse's phone: _______________________________________ Anniversary: __________________________________
Have you ever been separated? Yes_____ No______ When? _______________ For how long?______________
Your ages when married: Husband ________ Wife ________
How long did you know your spouse before marriage? ____
Give brief information about any previous marriages: ____
____
Information about children:
(Place a * next to the name of children from previous marriages)

Name	Age	Sex	Living?	Current school?	Marital status

Alcohol/Drug History

Do you drink alcoholic beverages? _______ If so, how much and how often to you drink?
____
Have you or a family member ever been concerned about your alcohol usage?
____
Have you ever been concerned about another family member's alcohol usage? _________ If yes, who?
____
Do you have a history of illegal drug or prescription drug usage? ______________________________________
Have you ever been concerned about another family member's illegal drug use or prescription drug use? ____

Religious Background/Information

Church Membership

Self ☐ KBC ☐ Visiting KBC ☐ Other Church Since________________

Spouse ☐ KBC ☐ Visiting KBC ☐ Other Church Since________________

Briefly describe your church experience as a child: ____
____
Religious background of spouse (if married): ____

Do you believe in God? Yes____ No_____ Uncertain_______
Do you believe in Satan? Yes_____ No_____ Uncertain______
How would you describe your prayer life? Occasional Daily As Needed Intimate
Would you say you are a Christian? Yes_____ No_____ Uncertain_____
How often do you read the Bible? Never____ Occasionally____ Several times a week____ Daily_____
Explain recent changes or growth in your relationship with God, if any: ______________________________
____

Spiritual Perspectives

1. Who is God? ____
____
2. Who is Jesus Christ? What has He done, and what is He doing now? What place does He have in your life? ____
____
____
3. I know that I am (or am not) a Christian because.... ____
____
____
4. The Bible is... ____
____
5. I feel guilty when... ____
____
____
6. I think I need to grow spiritually in the area of... ____
____
____

Thank you for taking the time to answer these questions thoroughly and honestly!