Lunday Counseling Center

4100 Legendary Dr., Suite 220, Bldg A
Destin, FL 32541
850-424-5515

Dx code: _____

Adult Information

Welcome to Lunday Counseling Center. In order to gain a better understand of you and your needs, please complete the following information.

Name: _____ Date: _____

Street Address: _____ City, State, Zip:_____

Age: _____ Date of Birth: _____

Can we write you here? Yes / No

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Can we leave a message at: Home: Yes / No Work: Yes / No Cell: Yes / No

Can we text you on your cell phone? Yes / No

Email: _____

Can we email you here? Yes / No

Your Marital Status: □ Single

□ Married: How long? _____; When? _____ (mo/yr);
# of marriages _____
□ Separated: How long? _____; when? _____ (mo/yr)
□ Divorced: How long? _____; When? _____ (mo/yr)
□ Widowed: How long? _____; When? _____ (mo/yr)

Current Spouse's Name (if applicable) _____ Age _____

Spouse's Phone (in case of emergency): _____

Previous Spouse's Name(s) - *if applicable*: _____

Names of children (If single, list parents and siblings)

First name	Last name	Age	Lives in your home
_____	_____	_____	□ Yes □ No □ Part time
_____	_____	_____	□ Yes □ No □ Part time
_____	_____	_____	□ Yes □ No □ Part time
_____	_____	_____	□ Yes □ No □ Part time

Employed: □ Yes □ No If yes, occupation: _____

Company name: _____ How long? _____

Have you had employment difficulties? □ Yes □ No If yes: □ current □ past

Who can we contact in case of an **emergency**? (Must be an adult other than spouse)

Name: _____ Phone: _____

Address: _____ Relation:_____

I give consent to release information about my treatment to the following people:

_____ _____
Name Relation to self

_____ _____

Name Relation to self

Medical Information

How would you rate your current physical health? □ Excellent □ Good □ Fair □ Poor

Are you currently experiencing any physical problems (e.g. headaches, body aches, stomach problems)?

□ Yes □ No If yes, please explain: _____

Previous hospitalizations for medical reasons Date:_____ Reason: _____

Medical conditions or disabilities: _____

Has either parent had medical problems? □ Yes □ No

If yes, Please explain: _____

Learning or other disabilities not listed: _____

Are you currently sexually active? □ Yes □ No If yes, how many current sexual partners? _____

Same sex or opposite sex? □ Opposite □Same Have you experimented with same sex? □ Yes □ No

Have you ever had an abortion? □ Yes □ No

How many? ___ How long ago? ____ How many weeks at time of abortion? _____

Are you currently experiencing any stress or regret over your abortion?

Please list all **non-psychiatric** medications: (over the counter or prescription):

Medication	Dosage	Frequency	Reason for taking

Have you ever abused prescription drugs (including taking drugs not prescribed to you)? □ Yes □ No

If yes, which types and when? _____

Have you ever abused non-prescription drugs (such as marijuana, heroin, methamphetamine)? □ Yes □ No

If yes, which types and when? _____

Have you ever abused alcohol? Yes □ No

If yes, what and when? _____

Are there any other addictions you are currently struggling with, or have struggled with in the past? Including, but not limited to, food, gambling, pornography, etc. _____

Counseling and Psychiatric Information

Have you had previous counseling? □ Yes □ No If yes, when? _____

Name and location of counselor: _____

If yes, for what reason? _____ For how long? _____

What were the results?_____

Have you ever been diagnosed or treated for any type of mental illness? □ Yes □ No

If yes, which type? _____

Please list any other disorders not already mentioned:_____

Has anyone in your family ever been diagnosed with or treated for any type of mental illness?

□ Yes □ No If yes, which type? _____

Have you ever suffered from any form of abuse? □verbal/emotional/mental □physical □sexual

By whom: _____

Are you presently having thoughts of harming yourself or others? □ Yes □ No

If yes, explain: _____

Have you ever attempted to complete homicide? □ Yes □ No

If yes, When? _____how? _____

What action was taken? _____

Have you ever attempted to complete suicide? □ Yes □ No

If yes, When? _____how? _____

What action was taken? _____

Is there a history of suicide in your nuclear or extended family? □ Yes □ No

If yes, Who? _____when? _____

Have you ever, or are you currently self-mutilating/self-harming? □ Yes □ No

If yes, When? _____how often? _____ Where on your body?_____

Please list all **psychiatric** medications:

Medication	Dosage	Frequency	Reason for taking

Are you currently seeing any other medical physicians? □ Yes □ No

	Name	**Address**	**Phone**	*** Initial for consent to contact**
Physician				
Gyn/OB				
Psychiatrist				
Dietitian				
Counselor				
Other				

** Will need to complete "Release of information" form in order to contact any of above*

Family Relationships

How does your family interact? _____

How does your family handle conflict? _____

What does your family enjoy doing together? _____

On a weekly basis, how much time does your family spend together? _____

Reasons for seeking counseling

What concerns have brought you to counseling today? _____

_____

Please rate the severity of your present concerns on the following scale.

Check one: □ Mild □ Moderate □ Severe □ Totally Incapacitating

What recent event prompted you to seek counseling at this time? _____

_____

Where are your concerns causing the most difficulty for you? Please check all that apply**:**

□ Home □ Dating Relationship □Marriage □ Children □ Health □ Job □ Finances

□ Extended Family □ Relationship with God □ Other: _____

When did your present concerns begin to be a problem for you? _____

What concerns about you have been identified by others? _____

Please check how often the following ***thoughts*** that occur to you:

1. Life is hopeless. ___ Never ___ Rarely ___ Sometimes ___ Frequently
2. I am lonely. ___ Never ___ Rarely ___ Sometimes ___ Frequently
3. No one cares about me. ___ Never ___ Rarely ___ Sometimes ___ Frequently
4. I am a failure. ___ Never ___ Rarely ___ Sometimes ___ Frequently
5. Most people don't like me. ___ Never ___ Rarely ___ Sometimes ___ Frequently
6. I want to die. ___ Never ___ Rarely ___ Sometimes ___ Frequently
7. I want to hurt someone. ___ Never ___ Rarely ___ Sometimes ___ Frequently
8. I am so stupid. ___ Never ___ Rarely ___ Sometimes ___ Frequently
9. I am going crazy. ___ Never ___ Rarely ___ Sometimes ___ Frequently
10. I can't concentrate. ___ Never ___ Rarely ___ Sometimes ___ Frequently
11. I am so depressed. ___ Never ___ Rarely ___ Sometimes ___ Frequently
12. God is disappointed in me. ___ Never ___ Rarely ___ Sometimes ___ Frequently
13. I am disappointed with God ___ Never ___ Rarely ___ Sometimes ___ Frequently
14. I can't be forgiven. ___ Never ___ Rarely ___ Sometimes ___ Frequently
15. Why am I so different? ___ Never ___ Rarely ___ Sometimes ___ Frequently
16. I can't do anything right. ___ Never ___ Rarely ___ Sometimes ___ Frequently
17. People hear my thoughts. ___ Never ___ Rarely ___ Sometimes ___ Frequently
18. I have no emotions. ___ Never ___ Rarely ___ Sometimes ___ Frequently
19. Someone is watching me. ___ Never ___ Rarely ___ Sometimes ___ Frequently
20. I hear voices in my head. ___ Never ___ Rarely ___ Sometimes ___ Frequently
21. I am out of control. ___ Never ___ Rarely ___ Sometimes ___ Frequently

Please indicate which of the following are **current** ***issues*** for you. Check all that apply:

- ☐ Not being able to say what you really think or feel
- ☐ Under too much pressure and feeling stressed
- ☐ Feeling down or unhappy/depressed mood
- ☐ Excessive anxiety or worry
- ☐ Withdrawing from others
- ☐ Suspicious feelings toward other people
- ☐ Afraid of being on your own
- ☐ Angry feelings
- ☐ Concerns about finances
- ☐ Feeling "numb" or cut off from emotions
- ☐ Concerns about physical health
- ☐ Concerns about emotional stability
- ☐ Tremors
- ☐ Blackouts or temporary loss of memory
- ☐ Insomnia (not being able to sleep)
- ☐ Loss of appetite/increased appetite
- ☐ Uncontrollable anxiety or worry
- ☐ Lacking self-confidence
- ☐ Feeling sexually attracted to members of your own sex
- ☐ Eating and then vomiting to control weight
- ☐ Excessive use of alcohol
- ☐ Abuse of non-prescription drugs
- ☐ Loss of interest in usual activities/lack of motivation
- ☐ Heart Palpitations
- ☐ Other: _____
- ☐ Feeling inferior to others
- ☐ Angry outbursts
- ☐ Excessive fear of specific places or objects
- ☐ Difficulty making friends
- ☐ Difficulty keeping friends
- ☐ Feeling as if you'd be better off dead
- ☐ Feeling manipulated or controlled by others
- ☐ Difficulty making decisions
- ☐ Loss of interest in sexual relationships
- ☐ Feeling Fat
- ☐ Feeling distant from God
- ☐ Hallucinations
- ☐ Hypersomnia (sleeping all the time)
- ☐ Inability to concentrate while at school/work
- ☐ Crying spells
- ☐ Feeling "on top of the world"
- ☐ Nightmares
- ☐ Getting into trouble at school/work
- ☐ Obsessions or compulsions with specific activities
- ☐ Inability to control thoughts
- ☐ Feeling trapped in rooms/buildings
- ☐ Hearing voices
- ☐ Feeling that people are "out to get you" or that you are being watched
- ☐ Memory Problems
- ☐ Chest Pain/Pressure

What do you hope to gain from counseling? _____

_____

_____

_____

_____

Strengths and Helps

What personal strengths do you feel you possess that may help you with your current difficulties?

_____

_____

Who or what has helped you cope with your current difficulties? _____

_____

Who or what has helped you cope with past difficulties? _____

_____

Spirituality

Do you believe in God? □ Yes □ No What is your religious preference (denomination)? _____

Are you a member of a church? □ Yes □ No If yes, which church? _____

How much influence does your religion or spirituality have on your day-to-day activity?

□ a great deal □ moderate amount □ little □ none

Do you believe that:

Absolute moral truth exists □ Yes □ No □ Not sure

The Bible is totally accurate in the principles that it teaches □ Yes □ No □ Not sure

Satan is considered to be a real being or force, not merely symbolic □ Yes □ No □ Not sure

A person cannot earn their way into Heaven by trying to be good or do good works □ Yes □ No □ Not sure

Jesus Christ lived a sinless life on earth □ Yes □ No □ Not sure

God is the all-knowing, all-powerful Creator of the world who still rules the universe today □ Yes □ No □ Not sure

Resource: The Barna Group

If you would die today, would you go to heaven? □ Yes □ No □ Not sure

Let's say you did die today and you were standing before God and God asked you, "Why should I let you into My heaven?", what would you say? _____

_____

_____

_____

Referral information

How did you hear about Lunday Counseling Center?

□ Friend _____ □ Daycare _____
□ Church _____ □ Pastor/Minister _____
□ Doctor's office _____ □ School _____
□ Internet □ Other: _____

Can we thank them for the referral? _____ If so, make sure to put their name and contact info on space below. Thanks!

_____

Thank you so much for choosing Lunday Counseling Center. Please continue to pray as you continue in counseling. Counseling can sometimes be a difficult time, so I would ask that you pray for the guidance of the Holy Spirit to move in and through this process. Not only pray for yourself, but pray for me, that I will allow the Holy Spirit to be my mouthpiece and guide me in helping you. Pray for your family. This time may also be a trying time for them. If you have any questions, please do not hesitate to ask.