PRESCREEN

CLIENT/GUARDIAN REPORT

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Christian Behavioral Therapy that is evidence based and biblically sound

All questions contained in this self-reported questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*			❑ M ❑ F	**DOB:**	/ /
Address:			**Phone:**		
Marital status:	❑ Single ❑ Partnered ❑ Married ❑ Separated ❑ Divorced ❑ Widowed. **Date of last change**: _____				
Legal status:	❑ Minor ❑ Minor in the guardianship of: _____ ❑ Adult ❑ Adult under guardianship				
Primary Care Physician:		**Referral Source:**			
Insurance:		**Member ID:**		**Group #:**	

PRESENTING PROBLEM

WHAT PROBLEMS HAVE BROUGHT YOU INTO TREAMTENT TODAY AND HOW ARE THESE IMPACTING YOUR CURRENT FUNCTIONING?

LIST OF SYMPTOMS

	Depressed Mood		Unexplainable Weeping		Excessive worrying		Distrust
	Shortness of breath		Restlessness or fidgety		Fatigue or low on energy		Hallucinations
	Frequent headaches		Nervousness		Inflated self-esteem		Confusion
	Legal problems		Racing thoughts		Gastrointestinal problems		Irritability
	Impulsivity		Work/School problems		Rapid heart beat		Nightmares
	Overeating		Emotionally numb		Fear of losing control		Flashbacks
	Blackouts		Phobia or fears		Fear of illness or dying		Loneliness
	Low Self-esteem		Interpersonal conflict		Feelings of shame or guilt		Hyperventilating
	Excessive sleep		Memory impairmnt L.T.		Marriage/Family Problems		Poor appetite
	Numbness/tingling		Sexual acting out		Disassociating from self		Dizziness
	Angry outbursts		Trembling or shaking		Fear of intimacy		Insomnia
	Sexual Dysfunction		Secretive/bizarre behavr		Poor concentration		Stress
	Obsessive thoughts		Social withdrawal		Cravings for Drugs/Alcohol		Repetitive Rituals
	Weight loss		Oppositional behavior		Disassociating from environment		Risky behavior

List your prescribed drugs and over-the-counter drugs, such as vitamins or herbals

Name the Drug	Dose/frequency	Pathology for which it is prescribed

List drugs of abuse, excluding alcohol but including over-the-counter & abused prescriptions

Name of Drug	Age 1st used	Last use date	Amount, Frequency and route of use when last using

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

EXERCISE	
	❑ Sedentary (No exercise)
	❑ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
	❑ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
	❑ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet	**A**re you dieting? ❑ Yes ❑No	
	If yes, are you on a physician prescribed medical diet? ❑ Yes ❑ No	
	Do you snack? ❑ Yes ❑No	
	Rank salt intake ❑ Hi ❑ Med ❑ Low	
	Rank fat intake ❑ Hi ❑ Med ❑ Low	
Alcohol	Do you drink alcohol? ❑ Yes ❑ No	**H**ave you tried to quit? ❑ Yes ❑ No When?
	How many days per week? ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7	**H**ave you any history of blackouts? ❑ Yes ❑ No
	How many drinks per day? ❑ 1 ❑ 2 – 4 ❑ 5 - 9 ❑ 10+	**If** yes, what kind?_
	Are you prone to "binge" drinking? ❑ Yes ❑ No	**D**oes your drinking concern you? ❑ Yes ❑No
		Do you drive after drinking? ❑ Yes ❑No
Tobacco	**A**re you currently smoking? ❑ Yes ❑ No	**H**ave you tried to quit? ❑ Yes ❑ No When?
	❑ Cigarettes – pks./day ____ ❑ Vape - #/day _____ ❑ Chew – #/day _____ ❑ Pipe - #/day _____ ❑ Cigars - #/day ____	
	Have you considered cutting back? ❑ Yes ❑ No	**A**ge you 1st began to smoke?
Sexuality	Are you sexually active? ❑ Yes ❑ No **L**ist contraceptive/barrier method used: ❑ None ❑ IUD ❑ Pill ❑ Condom	**A**ny discomfort with intercourse?
	List any sexually transmitted disease you have had: ❑ None ❑ Herpes ❑ Syphilis ❑ HPV ❑ Gonorrhea ❑ Hepatitis C	
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your therapist about your risk of this illness? ❑ Yes ❑ No	
Safety	Have you ever seriously thought about hurting yourself? ❑ Yes ❑ No	
	Have you ever attempted suicide? ❑ Yes ❑ No	**I**f yes, are you trying for a pregnancy? ❑ Yes ❑ No
	Have you any thought of killing someone else?	❑ Yes ❑ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	

MEDICAL HISTORY					
	Skin disorder		Heart or circulation problem		**RECENT CHANGE IN ANY BELOW:**
	History of head injury		Severe chronic pain		Weight
	Ears, nose or throat problem		Gastrointestinal problem		Energy level
	Diabetes		Bladder		Ability to sleep
	Multiple sclerosis		Hormonal imbalance		Control of bladder or bowel movement
	Thyroid or adrenal gland problem		Viral or bacterial infection		B vitamin level
	Epilepsy		Cancer		Hormone balance
	Stroke		Recent pregnancy		Other pain/discomfort:

FAMILY OF ORIGIN HISTORY

PLEASE LIST ANY MENTAL HEALTH OR SUBSTANCE ABUSE HISTORY (IF YOU'RE UNCERTAIN BUT SUSPECT A PROBLEM, MAKE NOTE OF THIS) OF EACH MEMBER OF THE FAMILY IN WHICH YOU GREW UP.

NOTE IF STEP OR ADOPTIVE	MENTAL HEALTH & SUBSTANCE ABUSE HISTORY	SIBLING NAMES	SEX	AGE	MENTAL HEALTH & SUBSTANCE ABUSE HISTORY
Mother			❑ F ❑ M		
Father			❑ F ❑ M		
Grandmother *Maternal*			❑ F ❑ M		
Grandfather *Maternal*			❑ F ❑ M		
Grandmother *Paternal*			❑ F ❑ M		
Grandfather *Paternal*			❑ F ❑ M		

CURRENT FAMILY HISTORY

CURRENT Significant Other	MENTAL HEALTH & SUBSTANCE ABUSE HISTORY	CHILDRENS NAMES	SEX	AGE	MENTAL HEALTH & SUBSTANCE ABUSE HISTORY
			❑ F ❑ M		
Past Significant Other			❑ F ❑ M		
			❑ F ❑ M		
			❑ F ❑ M		
			❑ F ❑ M		

LEGAL HISTORY

PLEASE LIST HISTORY OF ARRESTS, CONVICTIONS, AND INCARCERATIONS, AS WELL AS CURRENT PROBATION/PAROLE.

Do you have any outstanding warrants?	Yes ☐ No ☐	Upcoming trial?	Yes ☐ No ☐		
CRIME	**ARRESTED?**	CONVICTED?	IMPRISONED?	LENGTH OF PAROL?	LENGTH OF PROBATION?
	Yes ☐ No ☐	Yes ☐ No ☐	__ mnths __ yrs	__ mnths __ yrs	__ mnths __ yrs
	Yes ☐ No ☐	Yes ☐ No ☐	__ mnths __ yrs	__ mnths __ yrs	__ mnths __ yrs
	Yes ☐ No ☐	Yes ☐ No ☐	__ mnths __ yrs	__ mnths __ yrs	__ mnths __ yrs

EDUCATIONAL HISTORY

Highest level of education completed: ☐ 8th grade ☐ GED ☐ high school ☐ 1+ year of college ☐ college

☐	Not very social	☐	Very popular	☐	Advanced classes
☐	High achiever, in college	☐	Participated in extracurricular activities	☐	Behavioral problems
☐	Played sports in school	☐	Special education classes	☐	

VOCATIONAL HISTORY

OCCUPATION/JOB TITLE	PERIOD OF EMPLOYMENT	LAID OFF?	FIRED?	JOB LOSS DUE TO: ETOH/DR UGS? MENTAL ILLNESS?
	FROM: ____ **TO:** _____	Yes No	Yes No	

	From: ____ To: _____	Yes No	Yes No	Yes No	Yes No
	From: ____ To: _____	Yes No	Yes No	Yes No	Yes No
	From: ____ To: _____	Yes No	Yes No	Yes No	Yes No
	From: ____ To: _____	Yes No	Yes No	Yes No	Yes No

SPIRITUAL HISTORY

PLEASE LIST THE RELIGIONS THAT YOU IDENTIFY WITH CURRENTLY AND IN YOUR FAMILY TRADITION

Past	Now	Religion	Past	Now	Religion	PAST	NOW	RELIGION
☐	☐	Christian	☐	☐	Sunni	☐	☐	Shamanism
☐	☐	Jehovah's Witness	☐	☐	**Shi'ite**	☐	☐	Wicca
☐	☐	Mormon	☐	☐	Sufism	☐	☐	Spiritism
☐	☐	Judaism	☐	☐	Hinduism	☐	☐	Secular Humanism
☐	☐	Islam	☐	☐	Confucianism	☐	☐	Atheism
☐	☐	Babi & Baha'i	☐	☐	Buddhism	☐	☐	Agnosticism
☐	☐	Unitarian-Universalism	☐	☐	Taoism	☐	☐	Sikhism

OTHER:

Please write about your religious upbringing and spiritual journey and how this effects your current situation