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LIFECHANGE
SOUTHSIDE
Christian Church

Date: ___/___/_____

PATIENT INFORMATION

____
Last Name First Name M.I.
Previous Name

____
Address City State Zip
Phone Number
___/___/______________________________

Birthdate _______________ Age __________

Marital Status:
☐Married ☐Single ☐Divorced ☐Separated ☐Widowed ☐Partnered

____
Employer Address Work Phone
Occupation

☐Full Time ☐Part Time ☐Other:________________________________

EMERGENCY CONTACTS

____
Next of Kin (Spouse, Parent) Address Phone
Relationship

____
Second Contact (Friend, Relative) Address Phone
Relationship

MEDICATIONS (List all medications you are currently taking, including over-the-counter supplements)

Medication	Dosage/Frequency

PERSONAL HABITS

☐Yes ☐No Do you smoke regularly?
How many years?_____

☐Yes ☐No Do you usually drink over six cups of coffee per day?

☐Yes ☐No Do you regularly drink alcohol?
How many beers/day?______
How many glasses of wine/day?_______
How many ounces of hard liquor?______

☐Yes ☐No Do you have difficulty falling asleep?

☐Yes ☐No Do you awaken during the night?

☐Yes ☐No Do you awaken during the night and have difficulty falling back to sleep?

☐Yes ☐No Do you awaken early in the morning without apparent cause?

☐Yes ☐No Do you exercise regularly?

☐Yes ☐No Do you use other drugs? If yes, list type and frequency:___________________________________

Are you currently being treated by a physician? ☐Yes ☐No If yes, why?_____________________________
Name of Physician____

TREATMENT HISTORY

☐No prior treatment
☐Prior inpatient treatment: Explain/Dates:____
☐Prior outpatient treatment: Explain/Dates:____
☐Prior inpatient/outpatient psychological treatment:
Explain/Dates:____

Do you have, or have you recently had:

	Yes	No
Change in weight	☐	☐
Change in appetite	☐	☐
Chest pain	☐	☐
Chest tightness	☐	☐
Ankle swelling	☐	☐
Sinus infections	☐	☐
Stomach pain	☐	☐
Vomiting	☐	☐
Fainting	☐	☐
Loss of strength or sensation in any part of your body	☐	☐
explain:________________________________		
Nausea	☐	☐
Dizziness	☐	☐
Problems with sexual function	☐	☐
Anxiety	☐	☐
Hallucinations	☐	☐
Stroke	☐	☐
Change in memory	☐	☐

	Yes	No
Tremors	☐	☐
Sleep disorder	☐	☐
Paranoia	☐	☐
Head Injury	☐	☐
Toxic exposure	☐	☐
Epilepsy	☐	☐
Decreased concentration	☐	☐
Weakness	☐	☐
Fatigue	☐	☐
Shortness of breath	☐	☐
*at rest	☐	☐
*with exertion	☐	☐
*lying flat	☐	☐
Convulsions	☐	☐
Depression	☐	☐
Nervousness	☐	☐
Panic Attacks	☐	☐
Loss of Consciousness	☐	☐
Seizures	☐	☐

Who lives at home?____

FAMILY HISTORY

	Name	Sex (M/F)	Age	Health Concerns	Deceased Y/N	Cause
Father						
Mother						
Brother						
Sister						
Husband/Wife/Partner						
Sons						
Daughters						

Do you know of any blood relatives who have or had: (Circle and give relationship to you)

Suicide ______________________ Depression ______________________
Anxiety ______________________ Nervous Breakdown ______________________

Other family medical issues:

____

____

What do you consider to be some of your strengths?

____

____

____

What are your goals for counseling?

____

____

____

____

Patient Signature: _____________________________________Date:________________________