FAMILY CHRISTIAN COUNSESLING
3035 N. W. 63RD street, Suite 101, Oklahoma City, OK 73116

Part I: Comprehensive Adult Psychosocial/Treatment Plan
Confidential

Date: ________________ Referred by: ______________________________

___YES, I would like to receive the FCC newsletter BY E-MAIL. E-mail Address: ______________________________

CLIENT INFORMATION

NAME______________________________ GENDER: Male Female BIRTHDATE____________ AGE____

ADDRESS______________________________ HOME PHONE______________________

CITY____________________STATE_________ZIP__________ CELL PHONE______________________

How long have you lived at this location? ______yrs______mos Moved in the last 5 years?_____ Number of times ______

EMPLOYER______________________________ BUSINESS PHONE______________________

Okay to call you at work? Yes No Leave a message at work? Yes No

OCCUPATION______________________________ SOCIAL SECURITY NUMBER__________________

Have you changed jobs in the past 5 years? Yes No If yes, how many times?______________

Circle Highest Grade You Completed: 6 7 8 9 10 11 12 Fresh Soph Jr Sr Grad

College(s) Attended______________________________Degree(s) Received__________________

MARITAL STATUS ☐Single ☐Married (# times___) ☐Living as Married (# times___) ☐Separated ☐Divorced (# times___) ☐Widow(er) Length of time with current partner ______________________________

SPOUSE'S NAME______________________________ BIRTHDATE______________ AGE____

EMPLOYER______________________________ BUSINESS PHONE______________________

Okay to call your spouse at work? Yes No Leave a message at their work? Yes No

OCCUPATION______________________________ SOCIAL SECURITY NUMBER__________________

Has your spouse changed jobs in the past 5 years? Yes No If yes, how many times?______________

Circle Highest Grade Spouse Completed: 6 7 8 9 10 11 12 Fresh Soph Jr Sr Grad

College(s) Attended______________________________Degree(s) Received__________________

Names & ages of children ____

Do your children live with you? ☐Yes ☐No If not, with whom do they live?______________________________

Do you have problems with your children? ☐No ☐yes, describe______________________________

DESCRIBE YOUR PARTNER *Check all that apply*

☐warm ☐abusive ☐tense ☐unhappy ☐critical ☐distant ☐perfect ☐violent
☐affectionate ☐boring ☐caring ☐dependent ☐happy ☐indifferent
☐alcohol/drug/dependent ☐behavioral addiction ______________________________
☐other, *describe below*

Is there violence in the home? ☐No ☐Yes, Type: ☐mental ☐physical ☐emotional or verbal ☐spiritual

Do you have any of the following problems with your partner? ☐conflict over money ☐conflict over power
☐jealousy ☐abuse ☐difficulty w/ or conflict over sex ☐affairs ☐conflict over employment
☐conflict over children ☐relationship with partner is satisfactory ☐conflict over substance or behavioral addictions
☐have no current partner If so, are you concerned about lacking a significant relationship? ☐No ☐Yes

Additional comments:

ETHNIC GROUP ☐Caucasian ☐Black ☐Alaskan Native ☐Asian or Pacific Islander
☐American Indian, tribe ________________ ☐Hispanic________________ ☐Other ________________

CULTURAL INFORMATION *Check all descriptors that apply regarding who or what life events have had the most influence on you.*

☐Holidays ☐chaotic family ☐violence ☐trauma ☐disabilities ☐addictions
☐spirituality/ religion ☐family traditions ☐family culture ☐friends ☐neighbors ☐scouting
☐Learning/ education ☐school ☐sports ☐work ☐social ☐abuse
☐Foods ☐lifestyle choices ☐travel ☐reading ☐gender ☐social status
☐nontraditional roles or experiences ☐community organizations
☐other, *describe*____

Note the relationship(s) of those people who were instrumental in influencing your life either positively (+) or negatively (-) (mother, father, sibling, grandparent, aunt/uncle, stepparent, cousin, friend, etc.)____
____

PERSONAL RELIGIOUS INFORMATION: My spiritual beliefs are a significant factor in my life ☐No ☐Yes

☐I am involved in church / religion / spiritual practice. My church home is________________________

I attend (Circle) Several Times/Week Weekly Monthly Sporadically Seldom Never

My spouse attends (Circle) Several Times/Week Weekly Monthly Sporadically Seldom Never

My religious background is________________________. My spouse's religious background is________________.

Describe any significant religious experiences.

Describe any unexplainable experiences.

I have made the discovery of knowing Jesus Christ personally. ☐No ☐Yes Tell about your experience:__________
____

I am satisfied with my personal faith. ☐No ☐Yes
Additional Comments:

CHECK THE PROBLEM(S) FOR WHICH YOU ARE SEEKING HELP *Check all that apply*

☐crisis ☐trauma ☐child's behavior ☐school ☐family issue ☐work ☐isolated
☐anger ☐stress ☐medical ☐grief/loss ☐conflict ☐DHS ☐divorce
☐step-family ☐court ☐DUI ☐EAP referral ☐parenting ☐impulsive behaviors
☐bullying ☐marital ☐sibling issues ☐abuse ☐parent/child ☐communication
☐social skills ☐boundaries ☐problem solving skills ☐difficulty making/keeping friends
☐pre-marital ☐sexual conflict/guilt ☐problems w/ sexual partner ☐overwhelming emotions
☐sexual identity conflict ☐rape/ sexual assault ☐other, *describe*

Describe how long has this been a problem.____

Tell how have you already tried to solve the problem.____

	Low									High
How serious is this problem for you?	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
How hopeful are you that your life can be better?	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10

Describe how you want your life to be different as a result of counseling.________________________
____

How long do you think it will take to resolve the problem/s? ☐1-3 visits ☐2-3 months ☐6 months ☐other

Additional Comments: **Please include significant losses or life events in your lifetime (including experiences with pets) here.**

DESCRIBE YOUR STRENGTHS OR THE THINGS YOU DO WELL

MARK WHAT OR WHO YOU RELY ON FOR HELP OR NAME THE IMPORTANT RELATIONSHIPS IN YOUR LIFE.

☐faith ☐family ☐ friends ☐co-workers ☐neighbors ☐other, *describe*

DESCRIBE WHAT YOU DO FOR RECREATION OR FUN OR LEISURE—INCLUDE THE TYPE OF ACTIVITY AND THE FREQUENCY
(I.E., EXERCISE, WALKING/AEROBIC/JOGGING/WEIGHT TRAINING, 2X/WK, ETC.)

AFFECT/ MOOD--DESCRIBE YOUR EXPERIENCE *Check all that apply*

☐mood swings ☐depression ☐grief ☐anger ☐numbness ☐sadness ☐anxiety/anxiousness
☐low energy ☐don't care about anything ☐euphoria ☐overwhelmed ☐unable to cope with emotions
☐change in appetite/sleep patterns ☐thoughts of hurting myself or someone else (*suicidal/homicidal ideation/plan?)*

Additional comments:

THINKING/ MENTAL PROCESS, i.e. **DESCRIBE YOUR EXPERIENCE** *Check all that apply* ☐IQ score if MR ______

☐Oriented to person, time, place ☐memory problems (☐*short term* ☐*long-term*) ☐impulse control
☐ideas of guilt ☐difficulty concentrating ☐obsessive behaviors
☐disturbing nightmares or dreams ☐difficulty making decisions ☐dissatisfied with decisions made
☐feel persecuted or picked on ☐feelings of being unreal ☐suspicious of people or low trust
☐negative beliefs about yourself ☐ideas of hopelessness ☐ideas of worthlessness
☐preoccupied with sex ☐ideas of loss (incl. hopes/dreams) ☐other people cause my problems
☐can't shut down thoughts ☐follow my faith even when it causes problems for me

Delusions/hallucination ☐auditory ☐visual ☐delusions ______________________________

Additional comments:

FAMILY--DESCRIBE YOUR LIVING ARRANGEMENTS *Check all that apply*

☐living w/ spouse/ partner ☐living with biological family ☐living alone ☐living with relatives ☐adoptive family
☐living with friends ☐foster family ☐own/rent a private residence ☐residential care home
☐institutional setting ☐community shelter or homeless ☐other ______________________________

Please list the other individuals living in your home with you, including any who visit regularly

Name	Age	Relationship to you

Please list any additional family members living in your home on the back side of this page, including age and relationship.

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CLIENT NAME________________________________ **DATE**____________________

EDUCATIONAL/ OCCUPATIONAL/ VOLUNTEER HISTORY

Are you the primary person responsible for home management? ☐No ☐Yes
☐Volunteer, type of work____

Attitude toward school? ☐liked it ☐indifferent ☐disliked it Grades were primarily____________________

☐Now in school, where______________________________ ☐In learning disabilities/special classes in the past

Have you ever served in the military? ☐No ☐Yes Have you experienced war? ☐No ☐Yes
Do you have a service connected disability? ☐No ☐Yes, describe______________________________

Describe how you support yourself--include money from illegal or "under the table sources".
☐employment ☐social security ☐disability ☐food stamps ☐help from others ☐other ______________

Are you eligible for any public assistance? ☐No ☐don't know ☐Yes, ______________________________

What is your feeling/attitude towards your job? ☐like it ☐indifferent ☐dislike it

Problems on the job? ☐No ☐Yes, explain____

Have you ever been fired or laid off? ☐No ☐Yes Any medical reason you cannot work? ☐No ☐Yes, *describe*
____

Do you consider yourself ☐effective ☐impaired ☐ineffective in the roles identified above?
Additional Comments:

PERSONAL HISTORY

Describe any physical or emotional problems, of which you are aware, during your childhood: ____________________
____

Your primary caregivers during childhood were ☐birth parents ☐mother only ☐father only ☐father & stepmother
☐mother & stepfather ☐adoptive parents ☐foster parents ☐grandparents
☐other ______________________________ Place/ location of your birth__________________________

List the names & ages of all siblings ____

Do you have any difficulty remembering or describing your childhood? ☐No ☐Yes
Did your parents argue frequently? ☐No ☐Yes
If yes, was any physical violence involved? ☐No ☐Yes
Are your parents divorced? ☐No ☐Yes
Were you physically abused? ☐No ☐Yes, by whom______________________________

Did the family in which you grew up experience severe financial problems? ☐No ☐Yes

Has any inappropriate sexual behavior ever taken place around you or directed towards you? ☐No ☐Yes

If yes, by whom______________________________*(Name & Relationship)* Your age ______________
Additional Comments:

Describe Your Caregivers: mother (M), father (F); stepmother (SM), stepfather (SF); *In* Other Caregivers *column use initials to indicate that caregiver,* i.e., grandparent (GP); foster parent (FP); sibling (S), etc. *Check all that apply*

Warm ☐M ☐F ☐SM ☐SF☐OC Overprotective ☐M ☐F ☐SM ☐SF☐OC
Domineering ☐M ☐F ☐SM ☐SF☐OC Affectionate ☐M ☐F ☐SM ☐SF☐OC
Uncaring ☐M ☐F ☐SM ☐SF☐OC Fault-finding ☐M ☐F ☐SM ☐SF☐OC
Average ☐M ☐F ☐SM ☐SF☐OC Strict ☐M ☐F ☐SM ☐SF☐OC
Smothering ☐M ☐F ☐SM ☐SF☐OC Absent ☐M ☐F ☐SM ☐SF☐OC
Understanding ☐M ☐F ☐SM ☐SF☐OC Rejecting ☐M ☐F ☐SM ☐SF☐OC
Distant ☐M ☐F ☐SM ☐SF☐OC Perfect ☐M ☐F ☐SM ☐SF☐OC
Supportive ☐M ☐F ☐SM ☐SF☐OC Too little discipline ☐M ☐F ☐SM ☐SF☐OC
Alcohol/ drug dependent ☐M ☐F ☐SM ☐SF☐OC Behavioral addiction ☐M ☐F☐SM ☐SF☐OC
Depressed/ unhappy ☐M ☐F ☐SM ☐SF☐OC
*Additional Comments*____

Describe yourself as a child (C) or adolescent (A) *Check all that apply for your childhood and adolescence*

C A
☐☐Outgoing ☐☐Rebellious ☐☐Popular ☐☐Awkward ☐☐Unhappy ☐☐Aggressive ☐☐Quiet
☐☐Serious ☐☐Happy ☐☐Temperamental ☐☐Calm ☐☐Unpopular ☐☐Nervous ☐☐Angry
☐☐Thoughts of suicide ☐Other ____________________ ☐Things changed when I reached age________
because____

Check the following problems you experienced as a child (C) *and/or* adolescent (A) *Check all that apply*

C A
☐☐conflict w/ mother ☐☐conflict w/ father ☐☐conflict w/ siblings ☐☐conflict w/ stepmother
☐☐conflict w/ stepfather ☐☐conflict w/ peers ☐☐targeted by bully ☐☐conflict w/ teachers
☐☐conflict w/ police ☐☐conflict w/ neighbors ☐☐conflict w/ stepsiblings ☐☐overweight
☐☐anorexic/ bulimic ☐☐nightmares ☐☐excessive fear/worry ☐☐drug/ alcohol use
☐☐arrests/ delinquency ☐☐bedwetting ☐☐fire starting ☐☐cruelty to animals
☐☐sexual problems ☐☐attempted suicide ☐teen parent
☐☐other____

DO YOU HAVE ANY LEGAL ISSUES PENDING? ☐No ☐Yes Are you on probation or parole? ☐No ☐Yes
Do you have a legal/criminal record? ☐No ☐Yes Ever been arrested as an adult? ☐No ☐Yes
Have you ever been incarcerated? ☐No ☐Yes
Any current DHS/Court involvement? ☐No ☐Yes
If yes to any of the above, please describe ____

Will you want a letter sent to any of the following on your behalf? ☐No ☐Yes, then complete:

	Name	**Phone Number**	**Details**
DHS Caseworker			
Judge			
Parole/ probation officer			
Lawyer			
Other (Title)			

CONFLICT/ VIOLENCE/ TRAUMA ISSUES

Ever been threatened/ attacked/ afraid for safety/ life ☐No ☐Yes Experienced intimidation/ control ☐No ☐Yes
Grew up in a home with chronic problems ☐No ☐Yes Ever been a target of gender violence ☐No ☐Yes
Ever been target of racism/ discrimination ☐No ☐Yes Ever targeted by a bully at school or work ☐No ☐Yes
Additional Comments:

SUBSTANCE/ BEHAVIORAL ADDICTION HISTORY My family has a history of addictions ☐No ☐Yes
If yes, who? ☐grandfather ☐grandmother ☐father ☐mother ☐sibling ☐other relatives
☐I am concerned about my partner's use of substances/ behaviors
☐I am concerned about my child's use of substances/ behaviors
Please indicate the impact addictions have on your life, relationships, work, etc...

☐**I have a history of using/ abusing the following**

Substance or Behavior	**What and/or how much**	**Age of 1st Use**	**Age of last use or still using**	**Rt of administration:** oral, nasal, smoking, injection, other	**Received treatment &/ or attending 12 Step Group**
Alcohol					
Drugs					
Prescription Meds					
Tobacco					
Caffeine (incl tea,sodas)					
Gambling					
Excessive Computer use					
**Sex*					
***Codependency*					
****Food issues*					

* sex-includes pornography, several partners, etc
** codependency (focusing on others' behaviors, generally putting others first, feeling used & taken for granted)
*** food (includes excessive sugar, salt, junk foods, overweight, anorexia, bulimia)

MEDICAL/ PHYSICAL/ MENTAL HEALTH HISTORY
In your opinion what is your current level of health: ☐Excellent ☐Good ☐Fair ☐Poor
Please check any of the following that applies to you:
☐agitation ☐posture problems ☐tics/ tremors ☐walking difficulties ☐repetitive acts

In your opinion are you: ☐underweight ☐appropriate ☐overweight, by how many pounds____________________

To the best of your knowledge does anyone in your family experience:
☐depression ☐bipolar ☐schizophrenia Who? ☐mother ☐father ☐sibling
☐other family member—Who?________________________________

Are you currently being treated anywhere else? ☐No ☐Yes
Any previous EAP/ mental health services? ☐No ☐Yes
Have you ever been hospitalized for mental health problems? ☐No ☐Yes

Please provide details for any yes answer

OP/ EAP Therapist *or* Hosp. / Dr./ City	**Dates of Service**	**Reasons for Service**

Please list your personal physician and/or psychiatrist. FCC ***will not*** *contact your personal physician or psychiatrist without your written consent to do so. We maintain this information in the event of a medical emergency.*

Name	Address	Phone #	Date last seen

Please list the prescription & non-prescription medications, including vitamins, you are presently taking and those you have taken in the past 6 months:

Drug Name	Dose	Frequency	Prescribing Physician	Length of time on Drug	Benefits	Side Effects

Are you presently allergic to any foods or medications? ☐No ☐yes, please provide details

Check any symptoms you are currently experiencing:
☐fatigue ☐bloody sputum ☐cough lasting more than 2 weeks ☐sudden weight loss/gain ☐loss of appetite
☐weakness ☐chills ☐night sweats ☐fever ☐chronic health problem, provide details below

Does your health impact or limit your daily functioning in any way? ☐No ☐Yes, describe below.
Details to any question answered yes or any other additional comments:

Do you now have or have you ever had:
Hearing problems? ☐No ☐Yes
Not able to move a part of your body? ☐No ☐Yes
Pains in your chest? ☐No ☐Yes
Hands, feet or ankles that swells up? ☐No ☐Yes
Kidney trouble, trouble passing urine? ☐No ☐Yes
Decreased interest in sexual activity? ☐No ☐Yes
Trouble with constipation or diarrhea? ☐No ☐Yes
Severe headaches? ☐No ☐Yes
Goiter, thyroid problem? ☐No ☐Yes
Abnormal thirst or hunger? ☐No ☐Yes
Stomach trouble or ulcers? ☐No ☐Yes
Sleeping problems? ☐No ☐Yes
Liver disease, skin or eyes turn yellow? ☐No ☐Yes
Fainting spells, blackouts, falling, dizzy spells? ☐No ☐Yes
Eye problems, need glasses, increased pressure in eyes? ☐No ☐Yes
Any recent change in your appetite or eating habits? ☐No ☐Yes

Surgery/Surgeries? ☐No ☐Yes, date(s)/ type(s)____________________

Please check any that apply to you now or in the past:
☐measles ☐polio ☐German measles ☐meningitis ☐mumps
☐diphtheria ☐lupus ☐high blood pressure ☐pneumonia ☐glaucoma
☐rheumatic fever ☐skin problems/ diseases ☐thyroid disease ☐diabetes ☐heart problems
☐bleeding ulcers ☐mononucleosis ☐blood clots ☐anemia ☐epilepsy/ seizures
☐food poisoning ☐hepatitis ☐HIV positive ☐past allergies/ type __________
☐frequent colds/ flu ☐broken bones ☐concussions ☐knocked unconscious
☐dislocations ☐wounds ☐head injuries ☐chemical/ drug poisoning
☐cancer/ type________________ age______
☐sexually transmitted disease/ type________________ age contracted______

Males – are you now experiencing, or have you ever experienced either of the following?
☐enlarged prostrate ☐problems w/ impotence (getting or keeping an erection) ☐neither is applicable

Females Age at time of first menstrual period: ______ Flow: ☐Light ☐Average ☐Heavy

Is your menstrual cycle regular? ☐No ☐Yes Avg # of days____________

Mood difficulties related to your menstrual cycle? ☐No ☐Yes, *describe*______________________________

____

Are you still having periods? ☐No ☐Yes

Are you on hormone replace therapy ☐No ☐Yes

Are you now pregnant? ☐No ☐Yes Have you ever been battered while pregnant? ☐No ☐Yes

Pregnancy history: Total # of pregnancies ________ # of premature births _______

\# of c-section deliveries ________ # of stillbirths _______

\# of miscarriages ________ # of surgical abortions _______

DO YOU HAVE ANY PROBLEMS PROVIDING ANY OF THE FOLLOWING FOR YOURSELF OR YOUR FAMILY?

☐hygiene ☐food ☐clothing ☐shelter ☐transportation ☐medical/dental needs

Please check any of the following that apply: ☐fluent in English ☐fluent in (*other language)*__________________

☐English Second Language ☐hearing impaired ☐need interpreter ☐use signs ☐speech impaired ☐fluency issues

X____

Client's Signature Date

X____

Signature of Staff Person Completing Intake Date

DBN/2-11-2007