CY-HOPE COUNSELING
The Center for Children and Families

12715 Telge Rd.
Cypress, TX 77429
713.466.1360
www.cy-hopecounseling.org

Please complete the following questions about yourself prior to initial appointment.

DATE: ___/___/___

PATIENT NAME: _____ **BIRTH DATE:** ___/___/___ **AGE:** _____

NICKNAME(S): usually used_____ **SEX:** Male ☐ Female ☐

1. **DESCRIPTION OF CURRENT PROBLEM:**
   - **a.** Please describe symptoms and current functioning:
   - **b.** When did problem begin?_____
   - **c.** Was there a specific cause you can identify? No ☐ Yes ☐
     If yes, please describe:

2. **DESCRIPTION OF GOALS:**
   What behaviors do you hope to see through counseling process? (For example: "I will be more social with friends.")
   - **a.** _____
   - **b.** _____
   - **c.** _____

3. **FAMILY INFORMATION:** (please include significant other, children, or other important family members)

Family Member/ Significant Other/ Other	Age	Living with patient?	Relationship to patient	Occupation
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		

Describe how you get along with the above persons:

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4. HEALTH INFORMATION:

a. NUTRITION: Appetite is usually: Good ☐ Excessive ☐ Poor ☐ Variable ☐
Recent changes in appetite? No ☐ Yes ☐
If yes, please describe:

Is there a history of vomiting, binging, or excessive preoccupation with food? No ☐ Yes ☐
If yes, please describe:

b. SLEEP: Sleep is usually: Good ☐ Excessive ☐ Poor ☐ Variable ☐
Fall asleep normally? No ☐ Yes ☐
Wake more than twice in the night with trouble going back to sleep? No ☐ Yes ☐
Wake up earlier than needed without going back to sleep? No ☐ Yes ☐
If any other sleep concerns, please describe:

c. HEALTH AND MEDICATIONS:
Do you currently see a primary care doctor? No ☐ Yes ☐
Date of last visit? _____

Does the child have significant health concerns**?** No ☐ Yes ☐
If yes, please describe:

Does the child currently take medications, including for psychiatric reasons**?** No ☐ Yes ☐
If yes, please list medications with indications:

Please be aware that counselor encourages evaluation from medical doctor at onset of counseling to discuss behavioral and physical concerns.

d. SUBSTANCE USE: Not applicable ☐
Do you use, now or in the past, substances such as alcohol, marijuana or cocaine? No ☐ Yes ☐
If yes, please describe substances used, age of first use, and current usage patterns:

5. VIOLENCE/ABUSE: Please describe any physical, verbal, emotional, or sexual abuse as the perpetrator, victim, or witness you may have experienced **and impact on current treatment and functioning**. ☐ Not applicable.

_____

_____

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6. **TRAUMA:** Please describe history and any concerns/issues of manmade, natural, or other trauma that may **impact current treatment and functioning**. ☐ Not applicable.

_____

_____

7. **SEXUAL HISTORY:** Please describe history and any concerns/issues that may **impact current treatment and functioning** such as: age of first sexual encounter, sexual orientation, pregnancies, birth control, traumatic experiences, extra-marital affairs, at-risk behaviors, and sexual difficulties. ☐ Not applicable.

_____

_____

8. **EDUCATIONAL INFORMATION:** Please list highest education level completed:
   Any educational problems? No ☐ Yes ☐
   If yes, please describe:

9. **SPIRITUAL BACKGROUND:** Past and present religious affiliation, involvement in church, guiding spiritual principles:

   Do you have any spiritual concerns you would like to address?
   None ☐ Prayer ☐ Faith community ☐ Spiritual friend ☐ Spiritual reading ☐ Church attendance ☐ Other: _____

10. **LEISURE / HOBBIES:** What do you enjoy doing in your free time?

    What kind of activities do you do with family and peers?

11. **EMPLOYMENT/FINANCIAL INFORMATION:**
    Are you currently employed? No ☐ Yes ☐ If yes, current employer: _____
    Current occupation: _____
    Are your current troubles impacting your work? No ☐ Yes ☐
    If yes, please describe:

    How would you describe your current financial status? Describe any financial concerns you have currently:

    Do you need referrals to agencies to help with financial concerns? No ☐ Yes ☐

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12. **CHANGES:** Any recent changes such as moving, new job, family conflicts, etc.? None ☐ Yes ☐
If yes, please describe:

13. **MILITARY SERVICE:** Is anyone in the immediate family currently serving in the Armed Forces? No ☐ Yes ☐

Has past service in the Armed Forces affected this family's history and relationships? No ☐ Yes ☐
If yes, please describe, list service branch, dates, stations, and deployments as applicable:

14. **CULTURAL: Ethnicity / Race:** _____
Are there any family cultural values or traditions your counselor should be aware of? (Family organization, customs, etc.): No ☐ Yes ☐ If yes, please describe:

15. **PAST PSYCHIATRIC EXPERIENCES:** Please list names and dates of psychiatrists or hospitals, reason for visit, medications prescribed, and disposition:
None ☐

16. **PAST COUNSELING EXPERIENCES:** Please list names and dates of therapists or clinics you have attended, topic of counseling, and disposition:
None ☐

TESTING: If psychological or educational testing has been done, summarize findings: None ☐

17. **STRENGTHS AND DIFFICULTIES:** What strengths or talents do you have?

What difficulties or limitations do you have?

18. **OTHER INFORMATION:** Is there any other information about you that is helpful for your counselor to know?
None ☐

Thank you for taking the time to complete this form. The information is greatly beneficial to your counselor.

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Patient Health Questionnaire -PHQ9

Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling asleep, staying asleep, or sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
g. Trouble concentrating on things such as reading the newspaper or watching television				
h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
i. Thinking that you would be better off dead or that you want to hurt yourself in some way				
Totals				

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult At All	Somewhat Difficult	Very Difficult	Extremely Difficult
0	1	2	3