Cord of 3
Counseling Services, Inc.

Client(s) Name: _____ Date: _____

Spouse's Name (if applicable): _____

Church of Attendance: _____ Active Member: ☐ Yes ☐ No

Chief Complaint (What are the primary problems that have caused you to seek out counseling at this time?)
Medications: (All Current Medications You are Taking)

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Current Medications	Dosage	Prescribed by

LEGAL STATUS ASSESSMENT:

Are there any current/pending legal problems? ☐ YES ☐ NO

Are you on probation/parole? ☐ YES ☐ NO

Do you have previous legal history?
☐ YES ☐ NO

Will legal situation impact treatment?
☐ YES ☐ NO

ALCOHOL/DRUG HISTORY:

Any History of drug/alcohol use? ☐ YES ☐ NO

Please check any substances you have used/abused

☐ Alcohol	☐ Marijuana	☐ Stimulants	☐ Barbiturates
☐ Cocaine	☐ Hallucinogens (Acid/LSD)	☐ Methadone	☐ Pain Medications
☐ Crack	☐ Opiates	☐ Tranquilizers	☐ Over-the-counter Medications
☐ Tobacco	☐ Heroin	☐ Sedatives	☐ Crank
☐ Caffeine	☐ Inhalants		☐ Methamphetamine (Ecstasy, crystal meth)

☐ Other: _____

SOCIAL/EMOTIONAL SYMPTOMS

Please check any of the symptoms listed below which apply to you or your spouse:

	Current	History	N/A
Depressed mood	☐	☐	☐
Feelings of worthlessness	☐	☐	☐
Manic thought/behavior	☐	☐	☐
Crying spells	☐	☐	☐
Phobias	☐	☐	☐
Angry	☐	☐	☐
Anxious	☐	☐	☐
Obsessive/compulsive	☐	☐	☐
Changes in Appetite	☐	☐	☐
Change in Energy Level	☐	☐	☐
Sleep Disturbance	☐	☐	☐
Decreased Concentration	☐	☐	☐
Disorganized/Disoriented	☐	☐	☐
Laziness	☐	☐	☐
Social Withdrawal	☐	☐	☐
Binging/Purging	☐	☐	☐
Sexual Problems/Concerns	☐	☐	☐
Infidelity	☐	☐	☐
Homosexuality	☐	☐	☐
Hyperactive	☐	☐	☐
Lying/Manipulative	☐	☐	☐
Overworks	☐	☐	☐
Spends too much time online	☐	☐	☐
Property Destruction	☐	☐	☐
Is physically abusive	☐	☐	☐
Procrastinates	☐	☐	☐
Stealing	☐	☐	☐
Not a great listener	☐	☐	☐
Is a perfectionist	☐	☐	☐
Views Pornography	☐	☐	☐
Religious/Spiritual Concerns	☐	☐	☐
Talk of Suicide	☐	☐	☐
Hallucinations	☐	☐	☐
Excessive use of Alcohol/Drugs	☐	☐	☐

SAFETY RISK SCREENING:

Please Circle the number to the left if any of the following are true:	
	Risk Factors
1	Current/past psychiatric diagnosis: I have been diagnosed with a mood disorder, psychotic disorder, alcohol/substance abuse addiction.
1	Key Symptoms: I experience any of the following symptoms: depression, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations
2	Suicidal Behavior: I have a history of past attempts of suicide or self-injurious behaviors
1	Family: I have a family history of suicide or suicide attempts and/or a family history of mental health problems
1	Precipitating Factors: I have experienced public humiliation, shame or despair (i.e. loss of relationship, financial problems, health status changed) or I have been diagnosed with an ongoing medical illness
1	I have access to firearms
	Protective Factors
-1	I have the ability to cope with stress and I have religious beliefs against self-harm
-1	I have a responsibility to my children or loved ones and I have positive outlets for expressing myself and being understood
	Suicide Inquiry
2	I have a been thinking about suicide during the past ☐ 48 hours ☐ month ☐ Year
2	I know when, how and where I would commit suicide
2	I have attempted suicide in the past and I have rehearsed (literally or in my mind) how I would commit suicide or hurt myself
2	I have a desire to physically hurt someone else

Risk Level Score: _____

COUNSELING GOALS
Goals are very important in counseling. They provide your therapist with a focus and direction that will help us to help you. Please list the goal(s) that you want to address and reach in counseling. Please be specific.
1.
2.
3.
4.