

Yes No If yes, describe: _____

Any current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)?

Yes No If yes, describe: _____

F. MEDICAL INFORMATION: Doctor's names, address; and phone:

1. _____

2. _____

Are you presently taking any medication? Yes No If so, what? _____

For what purpose? _____

Any problems with: eating sleeping chronic pain recent weight changes

Describe any answers checked above: _____

Any other medical problems? _____

Have you or a family member ever been hospitalized for mental or emotional illness?

Yes No If yes, please explain - - dates, place, reason: _____

G. Common problem/symptom checklist. Fill in: 0=none, 1=mild, 2=moderate, 3=severe.

- | | | | |
|----------------------------------------|---------------------------------------------|-------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> marriage | <input type="checkbox"/> divorce/separation | <input type="checkbox"/> alcohol/drugs | <input type="checkbox"/> God/faith |
| <input type="checkbox"/> premarital | <input type="checkbox"/> child custody | <input type="checkbox"/> other addictions | <input type="checkbox"/> church/ministry |
| <input type="checkbox"/> singleness | <input type="checkbox"/> disabled | <input type="checkbox"/> grief/loss | <input type="checkbox"/> past hurts |
| <input type="checkbox"/> sexual issues | <input type="checkbox"/> work/career | <input type="checkbox"/> depression | <input type="checkbox"/> codependency |
| <input type="checkbox"/> family | <input type="checkbox"/> school/learning | <input type="checkbox"/> fear/anxiety | <input type="checkbox"/> intimacy |
| <input type="checkbox"/> children | <input type="checkbox"/> money/budgeting | <input type="checkbox"/> anger/control | <input type="checkbox"/> communication |
| <input type="checkbox"/> parents | <input type="checkbox"/> aging/dependency | <input type="checkbox"/> loneliness | <input type="checkbox"/> self-esteem |
| <input type="checkbox"/> in-laws | <input type="checkbox"/> weight control | <input type="checkbox"/> mood swings | <input type="checkbox"/> stress management |

Other (specify): _____

H. How did you hear about us?

- Website Yellow Pages Church Friend Family Member

Credit Card Authorization

Type of Card: Master Card Visa Discover American Express

Credit Card Number:

Expiration Date (MM/YY):

V-Code (3 Digit Security Code):

I consent and authorize Hines Family Counseling /Johnathan Hines, to provide assessment and/or counseling for myself and/or my minor child/children. Furthermore, I release Hines Family Counseling /Johnathan Hines from any legal liabilities. I understand that any sexual or physical abuse or threat of suicide will be taken seriously and reported to the proper authorities. I authorize Johnathan Hines / Hines Family Counseling to charge the above referenced credit card .

Name of Minor Child/Children: _____

Date: _____ Signature: _____

Date: _____ Signature: _____