Mimosa Christian Counseling Center, Inc.
220 Burkemont Avenue
Morganton, NC 28655

Client Profile Information

Client Name: _____ Record # _____

Date of Birth:_____ Medicaid # if applicable: _____

Address: _____

Home Phone #: _____ Mobile/Message # _____

Current living situation: ____live alone ____live with parents ____live with spouse ____live with relative ___ live with guardian ____number of children in the home ____number of siblings in the home ____number of children outside of the home ____others living in the home _____

Current Educational Status: ___Full-time ___Part-time ___Suspended ___Graduated ___Dropped Out
Grade: _____ School Attending: _____
# of Absences this year _____ # of Suspensions this year _____ Average Grades _____
Parent Name: _____ Work # _____
Current Employment Status: ___Full-time ___Part-time ___Unemployed ___Disabled ___Retired
Current Job Title or Position: _____
Current Employer: _____
Military History: _____
Highest Grade Completed in School: ____ College/Degree: _____
Other significant training/skills: _____
Hobbies/Interests: _____
What is your religious affiliation? _____
What church do you attend? _____
Do you or your family hold values, beliefs, or have a circumstance which would be important for us to consider or be sensitive to in helping you at this time?_____
Level of Spiritual Disciplines:

Prayer	____active	____fair	____poor	____none
Worship	____active	____fair	____poor	____none
Fellowship	____active	____fair	____poor	____none
Quiet Time	____active	____fair	____poor	____none
Bible Study	____active	____fair	____poor	____none
Service	____active	____fair	____poor	____none

Past/Present Participation in Self-help or Community Support Group: _____
_____
Past/Present Counseling/Psychiatric/Substance Abuse Treatment: _____
_____
Past/Present Involvement with Dept of Social Services: _____
Case Workers Name and Reason for Involvement: _____
_____

Client Name _____ Record # _____

Date of Birth:_____ Medicaid # if applicable: _____

Current Medical Conditions: _____
_____

Current Medications: _____
_____

Family Doctor: _____ Phone #: _____
Emergency Contact Name: _____ Phone #:_____

Please check any of the concerns listed below that apply to you.

___parents separated/divorced
___family problems
___sleep problems
___behavior problems at school
___feeling depressed/sad
___family financial problems
___feeling tired/no energy
___easily annoyed/irritated
___trouble concentrating
___loss of interest in people/things
___cry easily
___feelings of anger
___trouble with temper
___feelings of fear
___confusion
___feeling threatened/not safe
___feeling nervous/panicky
___thoughts of hurting myself (cutting, burning, etc.)
___thoughts of ending my life
___thoughts of hurting someone
___sexual concerns
___problems with alcohol/drugs
___often think of past trauma
___health problems
___feelings of guilt
___trouble with memory
___mood swings/changes
___problems controlling impulses (gambling, computers, eating, etc.)
___appetite/weight change
___difficulty keeping friends
___runaway behavior
___hearing voices/seeing things that others do not hear/see
___problems with transportation
___legal problems
___placement in group home
___placement in alternative school
___placement in residential treatment
___placement in special education classes
___history of sexual abuse
___history of physical abuse
___history of verbal abuse
___family history of domestic violence
___pregnancy
___truancy
___repeated grades
___mental health treatment
___excessive concern about weight
___aggressive behavior
___relationship problems

What do you hope to achieve by coming to counseling? _____
_____

_____ _____
Signature of Client Date

_____ _____
Signature of Legal Guardian or Responsible Party Date