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

Client Profile Information

Client Name: _____ Record # _____

Date of Birth:_____ Gender: ___ Male ___Female

Address: _____City:_____State:___ Zip: _____

Home Phone #: _____ Mobile/Message # _____

Email _____

Current living situation: ____live alone ____live with parents ____live with spouse ____live with relative ___ live with guardian

Who lives inside the home? (include name, ages, and relation to self)

_____

_____

_____

If the client is 18 or younger, please fill out the following;

If you are a current student what school are you attending and what grade are you in?

_____

_____

# of Absences this year _____

Has the child ever been suspended? If so please explain.

_____

What are the child's average grades?

_____ A's- B's

_____ B's-C's

_____ C's- D's

The next section asks more questions about education and employment history. Please skip if this does not apply to you or you are a parent filling this out for your child.

Educational History (Applies to those 18 years or older)

What is your current educational status? ___ Full-time ____Part-time ___ Not a Student

Highest Grade Level Completed? ___ High School ___College ___Some College ___Bachelors ___Masters ____Graduate or Higher

If you attended College what college did you go to? What is your degree in?

_____

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Employment History

Current Employment Status: ___Full-time ___Part-time ___Unemployed ___Disabled ___Retired

Current Job Title or Position:_____

Current Employer: _____

Military History:_____

Other significant training/skills: _____

Hobbies/Interests: _____

Spiritual Practices

Do you consider yourself to be a Christian? _____

Do you attend Church? If so what Church? _____

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? _____
_____

Please rate the following:

When it comes to spiritual disciplines how active are you or your family?

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

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Medical and Mental Health Treatment History

Please list you Primary Care Physician (include name and phone number)

_____

_____

Do you have any current medical conditions?

_____

_____

Please list any current medications.

_____

_____

Have you ever received mental health or counseling services? If so please describe.

_____

_____

History of Social Services Involvement

Has department of social services ever been involved with your family?
____ Yes ___ No

If yes please list your case workers name and contact information as well as the reason for involvement.

_____

_____

Legal History

Do you have any current or prior legal issues?

_____

_____

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In the following section please check any of the following symptoms that apply

___ parents separated/divorced
___ family problems
___ family history of domestic violence
___ relationship problems
___ family financial problems
___ problems with transportation
___ legal problems
___ difficulty keeping friends
___ sexual concerns
___ often think about past trauma
___ problem controlling impulses
___ problems with drugs or alcohol
___ low self esteem

___ feeling depressed/sad
___ feeling tired/ no energy
___ problems with sleep
___ loss of interest or pleasure in things or people
___ trouble concentrating
___ cry easily
___ feelings of guilt

___ feelings of anger
___ trouble with temper
___ aggressive behavior
___ thoughts of hurting others

___ feelings of fear
___ feeling threatened/ not safe
___ feeling nervous/ panicky
___ excessive worry
___ mood swings/changes in mood
___ easily annoyed/ irritated

___ confusion
___ trouble with memory
___ hearing voices/seeing things that other people do not see or hear
___ health problems
___ change in appetite or weight
___ excessive concern about weight

Do you have a history of:
___ behavior problems at school
___ placement in an alternative school
___ placement in special education classes
___ repeated grades
___ truancy
___ placement in a group home
___ placement in residential treatment
___ sexual abuse
___ physical abuse
___ verbal abuse

Are you currently experiencing any suicidal thoughts? ___ Yes ___ No
Have you experienced suicidal thoughts in the past? ___Yes ___No
Have you attempted suicide in the past? ___Yes ___No
Are you currently experiencing any violent or homicidal thoughts? ___Yes ___No

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

_____

_____ _____
Signature of Client Date

_____ _____
Signature of Legal Guardian or Responsible Party Date