

Your Previous Marriages (if applicable)

Date Children from this marriage

_____ to _____
_____ to _____

Spouse's Previous Marriages (if applicable)

Date Children from this marriage

_____ to _____
_____ to _____

RELIGIOUS BACKGROUND

Denominational preference _____

Church presently attended (name and address):

_____ Phone _____ Are you a member? Yes ___ No ___

Pastor _____ Permission to consult with pastor: Yes No

Do you believe in God? Yes ___ No ___ Uncertain ___

Do you consider yourself "Saved"? Yes ___ No ___ Not sure what you mean ___

Church attendance per month: 1 2 3 4 5 6 7 8 9 10+

Have you been baptized? Yes ___ No ___ How much do you read the Bible? Never ___ Occasionally ___ Often ___

If you were to die and stand before God and He asked you why He should permit you to enter Heaven, how might you respond?

MEDICAL HISTORY

(Have you had any of the following physical problems? Please check.)

- | | | |
|-----------------------|----------------------------|------------------------------|
| Heart problems__ | Bulimia__ | Menstrual irregularities__ |
| Liver problems__ | Anorexia__ | Kidney problems__ |
| Visual problems__ | Hallucinations__ | Head injury/concussion__ |
| Sensory distortion__ | Change in sexual drive__ | Stroke__ |
| Weakness__ | Seizures__ | Fatigue__ |
| Problems walking__ | Brain tumor__ | Heat/cold sensitivity__ |
| Unusual hair loss__ | Multiple Sclerosis__ | Rashes__ |
| Parkinson's disease__ | Bowel/bladder__ | Memory problems__ |
| Blackouts__ | Nausea/vomiting__ | Episodic disorientation__ |
| Amnesia__ | Weight change__ | Tremors__ |
| Impotence__ | Personality change__ | Thyroid dysfunction__ |
| Physical change__ | Deja vu__ | Diabetes__ |
| Constant hunger__ | Changes in consciousness__ | Hypoglycemia__ |
| Food cravings__ | Lung problems__ | Fever__ |
| Headaches__ | Allergies__ | Pneumonia__ |
| Dizziness__ | Cancer__ | Speech Problems__ |
| Stiff neck__ | High Blood Pressure__ | Incoordination__ Other _____ |

1) List all prescription & over-the-counter medications: Include diet pills, laxatives, birth control pills, cold and allergy medicines, aspirin.

2) How many hours of sleep do you average each night? Have there been any recent changes? Is this sleep restful?

3) Have you or others noticed any changes in your personality (anger, mood swings, withdrawal) thinking and memory, or work habits?

4) Rate your health: Very Good ___ Good ___ Average ___ Declining ___ Other _____

5) Have you ever had any psychotherapy or counseling before? Yes ___ No ___ (If yes, list counselor or therapist and dates.)

