Shirley Lytle, M.Div., LMHC, CSAT
Professional Counseling for Individuals, Couples, Family & Premarital
2025 112th Ave NE Bld.-2 Suite 100 Bellevue, WA 98004
(425) 998-7123

CONFIDENTIAL INFORMATION QUESTIONNAIRE

Please complete the attached questionnaire prior to our first meeting. It may seem like a lot of information; however it will provide an insight and help in our journey to your wholeness, living life fuller and with greater purpose.

Confidential Information Sheet

Date _____

PLEASE PRINT ALL INFORMATION

GENERAL INFORMATION:

Name: _____ Date of Birth: _____ Age: _____
Address: _____
City: _____ Zip: _____
E-mail: _____ Occupation: _____

CAN I EMAIL YOU FOR: (CIRCLE ALL THAT APPLY) SCHEDULING SERVICES UPDATES AVAILABLE GROUPS

Phone: Home: _____ Mobile: _____ Work: _____
OK to contact you at: Home- Y / N Mobile- Y /N Work- Y/ N

I typically will not identify myself as a Mental Health Counselor when I call to protect your privacy. Due to a variety of factors, sometimes people are difficult to reach or never receive messages. Please call me again if you do not hear from me. I am authorized to contact you as listed below:

Who I am authorized to communicate with:

Name: _____ Relationship: _____
Name: _____Relationship: _____

Briefly tell us about the concerns that have brought you here.

_____
_____
_____

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MARITAL STATUS:
Married: ____ Separated: ____ Widowed: ____ Divorced: ____ Never Married: ____
How long in present status? _____
Name of Spouse or Partner: _____
Phone: _____ Ok to contact: Yes___ No ____

Emergency Contact *(Other Than Spouse/Partner):*
Name:_____ Phone:_____ City:_____

CHILDREN:
Name: _____ Age: _____ Name: _____ Age: _____
Name: _____ Age: _____ Name: _____ Age: _____

COUNSELING HISTORY:
Have you received counseling before? Yes____ No ___ How long _____ Dates: _____
Name and address of Therapist: _____
_____

Results of your counseling as you see it: _____
_____
_____.
Have you ever been hospitalized for: Mental/Emotional reasons? Yes_____ No _____
Drug/ Alcohol Addiction? Yes_____ No _____
If yes, when and where? _____

Have you had any previous suicide attempts? Y/N Briefly describe _____
_____

How did you find about Living With Purpose? Referral ____ Internet _____ Church ____ Other _____

MEDICAL HISTORY:
Personal Physician: _____
Address: _____ Phone: _____

Are you on any medications now? Yes____ No _____
List prescriptions you are presently taking: _____
_____

List any major surgery, illnesses, accidents, or hospitalizations you have had: _____
_____

LWPC
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MEDICAL HISTORY (cont.):

Do you have an ulcer? Yes _____ No _____
Do you have any allergies? If yes to what? _____

Do you smoke? Yes _____ No _____
When did you begin smoking? _____ (age) For how long? ____
When did you quit smoking? _____ (age)

Do you have tension/pain in your body (e.g., neck, lower back, tremors, and fainting spells)?
Yes ___ No ____
If yes, where? _____ How long? _____

Do you have nightmares? Yes ___No ___ Sleepwalking? Yes____ No ____

What drugs have you used for other than medical purposes? How long did you use these? _____

Please list: _____

How often do you drink alcoholic beverages?
Never _____1-2 times/wk. ___ 3-4 times/wk. ____ 5-6 times/wk. ___ more ____

Have you noticed any loss of interest in sex, social activities, exercise, purpose, or etc...?
If yes, please list which areas: _____

Do you have any anxiety attacks or panic of any kind?

Please describe: _____

_____

Are you often "low" or depressed? Yes ___ No ____ Occasionally_____
Are you often "over-ambitious"? Yes ___ No ____ Occasionally ____
Are you unable to relax? Yes ___ No ____ Occasionally ____
Do you often feel "driven"? Yes ___ No ____ Occasionally ____
Have you ever had hallucinations? Yes ___ No ____ Occasionally ____

How often do you have suicidal thoughts? Occasionally ___ Rarely____ Never _____

Often Do you ever have memory lapses? Yes ___ No ___ Rarely ____

Do you ever find yourself in consistently dependent relationships?
Yes ___ No___ _Occasionally ___ Never ____

Are you a War Vet? Yes ___ No ___ Is your spouse? Yes ___ No ___

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Please check any current or past issues that still affect you or you would like to cover in counseling.

	Abortion		Emotions		Recreation
	Academic Issues		Faith		Relationship Concerns
	Addiction		Family Issues (*i.e. divorce, alcoholism, domestic violence*)		Relationship Issues
	Alcohol		Finances		School/Education
	Anger		Grief/Loss		Self-image
	Anxiety		Health		Sexual Abuse
	Business/Work		Homosexuality		Sexual Assault/Rape
	Childhood Abuse (*i.e. physical, sexual, emotional*)		In-laws		Sexual Identity Issues
	Children		Marriage Problems		Sexual Issues
	Co-dependency		Miscarriages		Social Activities
	Communication		Occult		Spiritual Concerns
	Conflicts		Organization		Spirituality
	Death of someone close		Pregnancy Issues		Stress
	Depression		Personality Enrichment		Suicidal thoughts
	Drugs		Pornography		Unwanted Weight
	Eating Disorders		Phobias (*type:*_____)		Other (_____)

If you currently experience any of the following symptoms, please rate them using the key below.

Never = 0 Seldom =1 Often = 2 Always = 3

_____Difficulty concentrating
_____Crying
_____Missing classes
_____Feeling helpless
_____Feeling uptight
_____Worrying
_____Feeling hopeless
_____Feeling afraid
_____Lying to others
_____Feeling out of control
_____Feelings of self-doubt
_____Injuring self
_____Nervous around others

_____Memory loss or blackout
_____Difficulty sleeping
_____Stealing
_____Anger
_____Eating binges
_____Drinking heavily
_____Other drug use
_____Guilt feelings
_____Withdrawing socially
_____Sexual preoccupation
_____Physical symptoms (i.e. headaches, digestive)
_____List:_____
_____Suicidal Thoughts
_____Other: _____

Please use the scale below to answer the following questions.

4=True to a great extent 3=Mostly true 2=Somewhat true 1=Not at all true

_____ My current concerns affect my success in life.
_____ My current concerns affect my ability to interact and connect with others.
_____ I am optimistic that I will be able to make some positive changes as a result of counseling.

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FAMILY HISTORY:

Your Family Background-
Using 3 words, describe your father _____
Using 3 words, describe your mother _____
Using 3 words, describe your stepfather/foster-father, or adoptive father _____
Using 3 words, describe your stepmother/foster-mother or adoptive mother _____
What is one problem area you saw in their marriage? _____
What is one aspect you like about their relationship?_____

Please list your brothers and sisters:
Name_____ Age____ Describe _____
Name_____ Age____ Describe _____
Name_____ Age____ Describe _____
Name_____ Age____ Describe _____
Name_____ Age____ Describe _____
Name_____ Age____ Describe _____

Spouse's Family Background-
Using 3 words, describe your spouse _____
Using 3 words, describe your mother-in-law_____
Using 3 words, describe your father-in-law_____
What is the one problem area in their relationship? _____
What is one aspect you like about their relationship?_____

Please list your spouse's brothers and sisters:
Name_____ Age____ Describe _____
Name_____ Age____ Describe _____
Name_____ Age____ Describe _____

RELIGIOUS BACKGROND: *This section is optional and each person's spiritual values will be respected.*

What is your spiritual or religious orientation? _____
Religious background in childhood _____
Name of religion I practice or church I attended then _____
Name of religion I practice or church I now attend _____
I am involved in spiritual/religious life: Very Committed 1 2 3 4 5 6 to Detached