

# Manna Treatment & Counseling

## General Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Employer: \_\_\_\_\_ Education: \_\_\_\_\_

What are the three most important problems that have brought you to our center at this time?

\_\_\_\_\_  
\_\_\_\_\_

How have you addressed these concerns already? \_\_\_\_\_

\_\_\_\_\_

What would you like to accomplish in therapy here? \_\_\_\_\_

\_\_\_\_\_

## Medical / Clinical Information

Describe your current health, including but not limited to diet and exercise: \_\_\_\_\_

\_\_\_\_\_

Please check the symptoms you are currently experiencing:

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Depression                 | <input type="checkbox"/> Weight Changes    | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Use of Drugs/ Alcohol |
| <input type="checkbox"/> Panic Attacks              | <input type="checkbox"/> Perfectionism     | <input type="checkbox"/> Difficulty Sleeping      | <input type="checkbox"/> Grief/ Loss           |
| <input type="checkbox"/> Body Aches/ Pains          | <input type="checkbox"/> Nightmares        | <input type="checkbox"/> Anxious/ Tense           | <input type="checkbox"/> Trauma                |
| <input type="checkbox"/> Lonely/ Isolated           | <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Inferiority Feelings     | <input type="checkbox"/> Relationship Prob.    |
| <input type="checkbox"/> Rage/ Anger                | <input type="checkbox"/> Hopelessness      | <input type="checkbox"/> Confusion                | <input type="checkbox"/> Sexual Concerns       |
| <input type="checkbox"/> Thoughts of Harming Others |  |   |  |

Have you ever been treated for a mental health problem with:

Counseling                       Medication                       Hospitalization

List your Health Care Provider(s): \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

Current medications: \_\_\_\_\_

\_\_\_\_\_

List current involvement with other mental health professionals: \_\_\_\_\_

**-continue on reverse-**

## Family/ Social Information

List parents, siblings, and any other significant members in your household growing up (Name, Sex, Current Age, Relationship to You):

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What was it like for you growing up in your family? \_\_\_\_\_

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List current partners, children, and/or others in your household (Name, Sex, Age, Relationship to You):

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What is it like for you in your current living situation? \_\_\_\_\_

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Do you feel you have adequate social support? Describe your current support system: \_\_\_\_\_

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Please check the following if appropriate:

	<u>You</u>		<u>Household Member</u>	
	Past	Present	Past	Present
Substance Abuse				
Neglect/Physical Abuse/ Family Violence				
Sexual Abuse				
Mental Illness				
Chronic Physical Illness				

List your denominational preference / church affiliation: \_\_\_\_\_

Active \_\_\_\_\_ Inactive \_\_\_\_\_