



THE LISTENING EAR COUNSELING AND MEDIATION SERVICES ENROLLMENT FORM

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INFORMATION FORM

The information below will allow us to understand you and your reasons for requesting counsel more effectively, enabling us to better help you. Please fill this out as completely as possible. All information is held in the strictest confidence and cannot be divulged to anyone without your written permission.

Client's Name _____ Age _____

Birth date _____ Social Security # _____

Address _____

City _____ State _____ Zip _____

Phone (home) _____ (work) _____ Best time to call _____

If minor, Parent/Guardian's name(s) _____

Marital Status: _____ Single _____ Engaged _____ Married _____ Separated _____ Divorced

DEMOGRAPHIC DATA

Place of Birth _____ Nationality _____

Religious Background _____ Place of Employment _____

Spouse's Place of Birth _____ Age _____ Nationality _____

Spouse's Religious Background _____ Place of Employment _____



THE LISTENING EAR CMS INFORMATION FORM (CONT'D)

YOUR FAMILY MAKEUP

Do you have children ____ How many ____ How many from previous marriage/relationship ____

Are you a blended family ____ how many of your children live in the house? ____ How many of your spouse's children live in the house? ____

List all children, and whether they live at home with you.

Name: _____ Age ____ Sex ____ Do they live with you? _____

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Name: _____ Age ____ Sex ____ Do they live with you? _____

Who is coming for counseling? _____ Any prior counseling? ____ Yes ____ No

If yes, when? _____ Where? _____ With whom? _____

Why? _____

Are you, or another family member currently seeing a psychiatrist or counselor? ____ Yes ____ No

If so, which family member(s)? _____

Name of counselor: _____ For what purpose? _____

Who referred you to us? (Name, relationship, and phone number)



THE LISTENING EAR CMS INFORMATION FORM (CONT'D)

If a professional referred you to us, may we send them a thank-you, noting your contact? ___ If yes, we will only send a thank-you. Any other contact requires your written permission.

Person to contact in an emergency (name, relationship, phone, address)

State the nature of the problem in your own words _____

What is your most difficult relationship right now? _____

What is your most difficult emotion right now? _____

CRISIS INFORMATION:

Any current suicidal thoughts, feelings, or actions?

___ Yes ___ No. If yes, explain: _____

Have you in the past or do you now have any current homicidal or assaultive thoughts, feelings, or anger-control problems?

___ Yes ___ No If yes, explain: _____

Any past problems, hospitalizations, or jailing for suicidal or assaultive behavior?

___ Yes ___ No If yes, explain: _____

Any current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)?

___ Yes ___ No If yes, explain: _____

MEDICAL INFORMATION:

Doctor's name _____ phone _____

Are you presently taking any medication? ___ Yes ___ No If so, what? _____

Any problems with eating, sleeping, chronic pain, recent weight changes _____ Describe any answers checked above: _____

Any other medical problems? _____



THE LISTENING EAR CMS INFORMATION FORM (CONT'D)

Have you or a family member ever been hospitalized for mental or emotional illness?

___ Yes ___ No If yes, explain: _____

Common problem/symptom rating. 0=none, 1=mild, 2=moderate, 3=severe

___ marriage ___ divorce/separation ___ premarital ___ child custody ___ God/faith ___ singleness
___ disability ___ grief/loss ___ Past hurts ___ alcohol/drugs ___ other addictions ___ church/ministry
___ sexual issues ___ work/career ___ depression ___ codependency ___ family ___ school/learning
___ fear/anxiety ___ intimacy ___ children ___ money/budgeting ___ anger/control ___ communication
___ parents ___ aging/dependency ___ loneliness ___ self-esteem ___ in-laws
___ weight control ___ mood swings ___ stress management

Other (specify): _____

FAMILY BACKGROUND

Was your PARENTAL HOME EVER BROKEN BY:

Death ___ Your age at the time? ___ How did you feel? _____

Divorce ___ Your age then? ___ How did you feel? _____

Separation ___ Your age then? ___ How did you feel? _____

Desertion ___ Your age then? ___ How did you feel? _____

Which parent in the above was lost from the home? _____

Did your mother or father remarry? ___ Your age then? ___

How did you feel about your stepparent? _____

Did you have a good or bad relationship with your:

Father ___ Explain: _____

Mother ___ Explain: _____

Brothers or Sisters ___ Explain _____

Did your family change residences? ___ How frequently? _____

How many schools did you attend? ___ Explain: _____

Was yours a closely-knit family? ___ Is it close now? _____



THE LISTENING EAR CMS INFORMATION FORM (CONT'D)

MARITAL BACKGROUND: Describe your relationship with your spouse

BIRTH ORDER

What is your placement in the family? (Circle one) 1 2 3 4 5 6 7 8 9 10 11 12 of how many? _____

Are you adopted? ____ Any adopted siblings? ____

If yes, what are their ages and how many are there? _____

If a twin, are you identical? ____

MILITARY SERVICE RECORD

Have you ever been in military service? ____ If yes, what branch? _____

Were you in combat? ____ If so, where? _____

Any military honors or medals? _____ Type of discharge? _____

EDUCATION

What is the highest grade you completed in school and in what year?

What is the highest degree you have received? _____

What was your major? _____ Minor? _____

OCCUPATION

Your occupation: _____

Your employer: _____ How long? _____

Employer's address: _____

Employer's telephone number: _____

What type of work do you do? _____

If you could do anything you wanted for employment, what would you be? _____



THE LISTENING EAR CMS INFORMATION FORM (CONT'D)

PERSONAL INFORMATION

Presently I believe my spiritual condition is: (Check one)

Poor Fair Average Good Excellent

Presently I believe my physical condition is: (Check one)

Poor Fair Average Good Excellent

Presently I believe my emotional condition is: (Check one)

Poor Fair Average Good Excellent

Check the items that best describe or relate to the reason you need to receive counseling:

Bereavement Religious doubts Depression Marriage problems Relationship with parents Relationship with children Hatred Bitterness Relationship with others Anxiety Sexual concerns Loss of faith in God Nervousness Adultery Loss of self-confidence Fear Impotency Mistrust of others Self-doubt Frigidity Hopelessness Guilt Homosexuality Loss of purpose Suicidal Anger with God Loss of feelings Loneliness Loss of love Loss of self-respect

If a female, have you had any discontinued pregnancies? _____

Have you ever been arrested for other than a traffic violation? _____

How old were you when you left your parental home? _____

Have you ever been institutionalized for any problem? _____

Symptoms or conditions you have had or are now experiencing:

CONDITIONS PAST (1) Present (2)

Mood highs or lows Weight loss/gain Appetite change Drug usage Cigarette usage Tobacco usage Irritability Excessive stress Crying spells Phobias or fears Hallucinations Confusion Low self-esteem Compulsion Depression Extreme nervousness Lack of motivation Excessive drinking Indecisiveness Loss of memory Fantasizing Insomnia Excessive worries Difficulty concentrating Hearing voices



THE LISTENING EAR CMS INFORMATION FORM (CONT'D)

CONDITIONS ___ PAST (1) ___ Present (2)

___ Frequent loss of temper ___ Acting out violence ___ Frequent employment changes ___ Frequent residence changes ___ Bed-wetting past age 6 ___ Fire setting past age 6 ___ Blaming others frequently ___ Lack of sexuality awareness ___ Gender Confusion ___ Spiritual confusion ___ Suicidal Thoughts ___ Difficulty reading ___ Difficulty with math ___ Inability to express self ___ Involvement with the occult ___ Personal sexual abuse ___ Physical abuse of children ___ Physical abuse of others

BACKGROUND INFORMATION

How long has it been since you had a complete physical examination? _____

What physical disorder do you have, if any? _____

How many schools did you attend prior to any college? _____

Do you take vitamins? ___ Which ones? _____

Your favorite food? _____ Your favorite dessert? _____

How often do you eat it? _____ Do you snack often? _____

On what? _____

Do you use alcoholic beverages? ___ None ___ Some ___ Moderately Often ___ Every day

Is there a family history of alcoholism _____

Do you drink coffee? ___ Yes ___ No ___ Decaffeinated ___ Regular ___ Cups per day

Do you use tobacco regularly? ___ Yes ___ No ___ Some ___ Moderately ___ Heavy

Describe yourself in a few sentences:

Are you a Christian? ___ Yes ___ No ___ Not sure

What church do you now attend, if any?

How often do you attend? ___ Regularly ___ Frequent ___ Occasional



THE LISTENING EAR CMS INFORMATION FORM (CONT'D)

What are your two favorite colors?

Have you ever thought of committing suicide? ___

If yes, explain: _____

Have you ever attempted suicide? ___ When? _____

Do you ever think that perhaps you're going "crazy"? ___ If, yes, explain: _____

Do you ever simply want to run away? ___ If yes, explain: _____

Do you look forward to the future? ___ Yes ___ No

How do you feel about the past? ___ Good ___ OK ___ Guilty ___ Bitter ___ Angry ___ Confused

___ Wish you could change it?

What time period do you think about the most? ___ Past ___ Present ___ Future

Is there a family history of physical or emotional abuse? ___ If yes, please explain: _____

Were you ever sexually abused or molested? ___

Do you believe "your only problem" is the behavior of someone else? _____

If yes, please explain: _____

In your own words, complete this sentence: Sex is _____

Are vitamins and minerals important? ___ Why? _____

So that I may understand your problems fully, please state in your own why you chose a Christian mental

health professional. _____



THE LISTENING EAR CMS INFORMATION FORM (CONT'D)

You are responsible for any decisions you make regarding your life. Upon signing this document, you agree that you understand no one can guarantee you how successful your outcome will be after working with a counselor of The Listening Ear CMS (TLECMS) knowing that your success is determined by what you are willing to do and change.

With your understanding, YOU AGREE NOT TO TAKE ANY LEGAL ACTION WHATSOEVER AGAINST TLECMS, ANYONE WORKING WITH TLECMS, OR ITS AFFILIATES.

Signed: _____ Today's Date _____