

## Impact of Life Circumstances

Please check any LOSSES that you have experienced:

**Death:**

- |                                      |  |  |
|--------------------------------------|--|--|
| <input type="checkbox"/> Spouse      | <input type="checkbox"/> Divorce           | <input type="checkbox"/> Bankruptcy      |
| <input type="checkbox"/> Child       | <input type="checkbox"/> Separation        | <input type="checkbox"/> Homelessness    |
| <input type="checkbox"/> Father      | <input type="checkbox"/> Broken Engagement | <input type="checkbox"/> Career/job loss |
| <input type="checkbox"/> Mother      | <input type="checkbox"/> Suicide           | <input type="checkbox"/> Other: _____    |
| <input type="checkbox"/> Sister      | <input type="checkbox"/> Miscarriage       | <input type="checkbox"/>                 |
| <input type="checkbox"/> Brother     | <input type="checkbox"/> Abortion          |  |
| <input type="checkbox"/> Grandparent | <input type="checkbox"/> Infertility       |  |
| <input type="checkbox"/> Friend      |  |  |

Please check any VICTIMIZATIONS you have experienced or been involved with:

**Child Abuse:**

- Physical
- Emotional
- Sexual
- Incest
- 

**Spouse Abuse:**

- Physical
- Emotional
- Sexual
- Done to you?
- Or by you?

**Other:**

- Abandonment
- Rape
- Robbery
- Assault
- Suicide attempt

- Auto/Industrial Accident
- Major Illness
- Surgery
- Physical Disability
- Alienation

Please check any PROBLEMS that concern you now:

**Relationship(s)**

- Spouse
- Children
- Parents
- In-laws
- Co Workers
- Friends
- Teachers

**Other:**

- Alcohol
- Illegal Drugs
- Prescription Drugs
- Binge Eating
- Excessive Dieting
- Excessive Exercise
- Shopping
- Work Too Much

- Procrastination
- Communication
- Depression
- Anger
- Grief
- Gender Identity
- Sex
- Career

- Loneliness
- Mood Swings
- Self-esteem
- Codependency
- Stress
- Fear
- Anxiety
- Feelings about Church/God

**INTENSE EMOTIONAL DISTRESS/Current Situation**

**Explanation**

- |  |       |
|--|-------|
| Suicidal thoughts, plans, attempts       | _____ |
| Homicidal thoughts, plans, attempts      | _____ |
| Desire to cause pain to self or others   | _____ |
| In fear for your life or personal safety | _____ |
| Too depressed to care for self or family | _____ |

**IN SIGNING BELOW, I AFFIRM THAT THE INFORMATION GIVEN ON THIS FORM IS TRUE AND COMPLETE**

\_\_\_\_\_ Date \_\_\_\_\_  
 Client or Custodial Parent or Guardian for Minor Child

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_