

# WCRM

## Initial Evaluation Form

Please send to: 225 Patton Avenue Asheville, NC 28801

Fax 828-254-0428

### ***Personal/Family Record:***

**To make our first visit more productive, please give accurate and complete information. This will help to make a determination of your need and how we may help you. Please use the reverse side to expound on any question or add your own thoughts.**

Date \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_

Full Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Phone (home) \_\_\_\_\_ (work) \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Position \_\_\_\_\_

Social Security # \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Education: Grade Completed \_\_\_\_\_ Degree \_\_\_\_\_

Marital Status: Never Married \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widowed \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Occupation \_\_\_\_\_

Child's Name	Age	Sex	Relationship	Living in home Y/N
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

I was referred by: \_\_\_\_\_ Ph# \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Have you ever been in counseling/treatment before? \_\_\_\_\_ If yes give details:

Name of counselor, pastor, doctor, treatment, etc	Date(s)	Purpose
_____	_____	_____
_____	_____	_____
_____	_____	_____

Presenting Problems: \_\_\_\_\_

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

**STATE PICTURE ID AND SOCIAL SECURITY CARD REQUIRED BEFORE ADMISSION**

***Emotional History***

- \_\_\_\_\_ I don't remember being loved physically as a child (hugs, being held, etc)
- \_\_\_\_\_ My parents divorced when I was a child. I was \_\_\_\_\_ years old
- \_\_\_\_\_ I had no father growing up because of (circle one) death/divorce/preoccupation
- \_\_\_\_\_ One of my parents committed suicide. I was \_\_\_\_\_ years old.
- \_\_\_\_\_ I suffered abuse from a non-parental family member.  
Please identify the relationship: \_\_\_\_\_
- \_\_\_\_\_ I was sexually abused as a child. By whom? \_\_\_\_\_
- \_\_\_\_\_ I had (have) a physical/mental abnormality that brought ridicule from peers.
- \_\_\_\_\_ I experienced a severe trauma (house fire, accident, tragedy)  
Please explain \_\_\_\_\_
- \_\_\_\_\_ I was verbally abused as a child.
- \_\_\_\_\_ I have given up a child for adoption.
- \_\_\_\_\_ I have had a very unhappy marriage.
- \_\_\_\_\_ I had an alcoholic parent.
- \_\_\_\_\_ I was adopted.
- \_\_\_\_\_ I have felt abandoned by friends.
- \_\_\_\_\_ I suffer from low self-esteem.
- \_\_\_\_\_ I have had one or more abortions. How many? \_\_\_\_\_ When \_\_\_\_\_
- \_\_\_\_\_ I have had one or more miscarriages. How many? \_\_\_\_\_ When \_\_\_\_\_

Alcohol/Drug History (type, route, frequency, pattern, periods of abstinence, first use, last use, gambling/eating/sexual/other addictive issues) **Please list ALL** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Legal Status: Are you currently on parole, probation, under bond, or ordered by the court to seek treatment? If yes, for how long and for what? \_\_\_\_\_  
 \_\_\_\_\_

Parole/Probation Officer \_\_\_\_\_  
 Address \_\_\_\_\_ Phone# \_\_\_\_\_

**PLEASE NOTE: WE ARE NOT A MEDICAL FACILITY AND CANNOT GIVE MEDICAL CARE.**

Emergency Contacts: 1) \_\_\_\_\_ (2) \_\_\_\_\_  
 Address, phone number \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## *Spiritual History*

Because our ministry is based on biblical values and principles, the following information will be helpful in our assessment.

Religious background in childhood (briefly describe) \_\_\_\_\_

\_\_\_\_\_

Church Affiliation \_\_\_\_\_ Member \_\_\_\_\_

Pastor's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Are you a Christian? Yes \_\_\_\_\_ No \_\_\_\_\_ Uncertain \_\_\_\_\_ Need more information \_\_\_\_\_

If yes, I consider myself to be: 1 2 3 4 5 6

Committed      Detached

Church involvement: 1 2 3 4 5 6

Very Active      Detached

I have been personally involved in dabbling with or practicing the occult (please circle items) Ouija boards, séances, horoscopes, tarot cards, psychic power, astral travel, witchcraft.

Other (briefly describe) \_\_\_\_\_

\_\_\_\_\_

Have you ever been sexually involved with one who practiced witchcraft or Satanism? Yes \_\_\_\_\_ No \_\_\_\_\_

Describe any significant fearful experiences with "evil" \_\_\_\_\_

\_\_\_\_\_

Do you know of anyone in your blood ancestry who either was involved in non-Christian teaching or who practiced the Occult? (New age, metaphysics, cults, spiritualism, psychic power, tarot cards, Satanism, witchcraft, etc.) if so please identify:

Relationship

Involvement

\_\_\_\_\_

\_\_\_\_\_

The following (may) indicate spiritual oppression. Please check any that relate)

\_\_\_\_\_ Psychic abilities, clairvoyance, divination, feeling of having "special powers."

\_\_\_\_\_ Inward perception of a separate personality, name or voice that prompts undesirable thoughts or Behaviors.

\_\_\_\_\_ Fearful, repetitive night visitations by an evil presence

\_\_\_\_\_ Separation of mind from body – spacing out, dizziness

\_\_\_\_\_ Inability to focus on and retain Biblical truth

\_\_\_\_\_ Difficulty participating in prayer: agitation, nausea, anger, rebellion, etc

\_\_\_\_\_ Uncontrollable thoughts/impressions, sexual perversions, cursing violence

\_\_\_\_\_ Uncontrollable compulsive behaviors; sexual sin, anger, chemical indulgence

\_\_\_\_\_ Preoccupation with thoughts of death, despair, and hopelessness

\_\_\_\_\_ Uncontrollable, irrational, paralyzing fear

\_\_\_\_\_ Unusual, non-typical emotional expressions; laughter, sadness, crying anger

\_\_\_\_\_ Extreme nervousness or negative reactions at the mention of the name of Jesus

Please describe below any additional factors that lead you to suspect spiritual oppression:

Rate the issues that pertain to you. (rate the degree of stress/urgency for applicable areas ----1 (low) to 5 (high))

_____ Depression	_____ Chronic Illness	_____ Sexual Identity Problems	_____ Marital Problems
_____ Anxiety/Fear	_____ Loneliness	_____ Compulsive behaviors	_____ Drug addiction
_____ Alcoholism	_____ Insomnia	_____ Physical abuse	_____ Sexual Abuse
_____ Grief/loss	_____ Eating Disorder	_____ Emotional Abuse	_____ Low self Esteem
_____ Work holism	_____ Career Decision	_____ Occult Oppression	_____ Financial Crisis
_____ Relationships	_____ Mood swings	_____ Anger/Frustration	_____ Rejection
_____ Abandonment	_____ Adultery	_____ Loss of hope	_____ Suicidal Thoughts

Other Crisis Issues: \_\_\_\_\_

Suicidal thoughts, plans, attempts

Yes\_\_\_ No\_\_\_ Explain\_\_\_\_\_

Homicidal thoughts, plans, attempts

Yes\_\_\_ No\_\_\_ Explain\_\_\_\_\_

Desire to inflict pain to self or others

Yes\_\_\_ No\_\_\_ Explain\_\_\_\_\_

In fear of life or personal safety

Yes\_\_\_ No\_\_\_ Explain\_\_\_\_\_

Too depressed to care for self or family

Yes\_\_\_ No\_\_\_ Explain\_\_\_\_\_

Have you had any major surgeries, illnesses, or accidents? Please describe

## MEDICAL INFORMATION

Family Doctor\_\_\_\_\_

Psychiatrist/Psychologist\_\_\_\_\_ **Diagnosis**\_\_\_\_\_

Are you taking medication Yes\_\_\_ No\_\_\_ List medications \_\_\_\_\_

Who is prescribing?\_\_\_\_\_

Describe your physical health\_\_\_\_\_

Have you taken medication for emotional stress?

Yes\_\_\_ No\_\_\_ Explain\_\_\_\_\_

Have you ever been hospitalized for emotional or mental illness or substance abuse?

Yes\_\_\_ No\_\_\_ Explain\_\_\_\_\_

When was your most recent physical?\_\_\_\_\_

Physician who conducted physical\_\_\_\_\_

Any significant findings\_\_\_\_\_

Recommended treatment\_\_\_\_\_

History of convulsions, seizures, blackouts\_\_\_\_\_

