



A New Life
Christian Counseling

A New Life Is Possible One Step at a Time

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IMPORTANT INSTRUCTIONS FOR FILLING OUT FORMS

Welcome to A NEW MAN Abuse Prevention Program. Your Intake Counselor will be with you shortly. Please use the time now to fill out the following forms. Please use a pen (not pencil) to fill out the forms.

These questions and forms are necessary for you to complete in order to fulfill the WA State Administrative Code for Certified Domestic Violence Treatment. Answering them accurately is also helpful to provide you with the best treatment experience possible. The more we understand about you, your history and your individual situation, the more we will be able to help you. However, if you find some of the questions too uncomfortable, feel free to skip them for now and we can address them during the interview.

These forms take time and effort on your part. Completing them outside of your interview time will enable you to finish your interview with your counselor in the time allotted. Please have any specific questions from these forms ready to ask your Intake Counselor.

Thank You.



Today's Date: ____ / ____ / ____

Personal Information

Name:		Age:	DOB: / /
(Circle All that Apply): Single Dating Married Separated Divorced		Cell Phone #: () -	
Address:		Home Phone #: () -	
City:	State:	Zip:	Work Phone #: () -
# of Children:	Their Ages:	Msg. Phone #: () -	
Current Partner's Name (If Applicable):		Their Phone #: () -	

List everyone currently living in your residence, including family and other:

NAME	AGE	RELATIONSHIP
Nearest Relative Living Separately:		Their Phone #: () -

Education / Employment Information

Last grade completed in school:	Are you employed now? ____Yes ____No
Present Occupation:	Company Name:
Main occupation during past 5 years:	

Spiritual History

Name of Person(s) Who Introduced You to Christ:	Age at Conversion:
List a Few Words to Describe Your Personal Faith:	
List Those Who Support You Most Spiritually:	

General Information

Briefly describe incident that resulted in referral to DV Treatment: _____

Please list your original charge(s): _____

Please list any amended/plea bargain charge(s): _____

Please circle any of the following which concern you:

- | | | | |
|-------------------|------------------------|-----------------|------------------|
| NERVOUSNESS | DEPRESSION | FEARS | SHYNESS |
| SEXUAL PROBLEMS | SUICIDAL THOUGHT | SEPARATION | DIVORCE |
| FINANCES | ANGER | SELF-CONTROL | FRIENDS |
| SLEEP PROBLEMS | STRESS | WORK/SCHOOL | RELAXATION |
| HEADACHES | TIREDDNESS | LEGAL MATTERS | MEMORY |
| AMBITION | ENERGY | INSOMNIA | MAKING DECISIONS |
| LONELINESS | INFERIORITY FEELINGS | CONCENTRATION | EDUCATION |
| CAREER CHOICES | MARRIAGE/RELATIONSHIPS | HEALTH PROBLEMS | TEMPER |
| NIGHTMARES | CHILDREN | EATING PROBLEMS | UNHAPPINESS |
| SEXUAL ABUSE | PHYSICAL ABUSE | BOWEL TROUBLES | BEING A PARENT |
| MY THOUGHTS | STOMACH PROBLEMS | GAMBLING | BINGE EATING |
| EATING TOO LITTLE | TOO HEAVY OR THIN | SPIRITUALITY | UNFORGIVENESS |

Please circle any of the following strengths you have:

- | | | | | |
|------------|-------------|---------------|----------------|---------------|
| CONFIDENT | HARD WORKER | ORGANIZED | SYMPATHETIC | GOOD LISTENER |
| DEPENDABLE | SENSITIVE | LOGICAL | LOYAL | GRACIOUS |
| DECISIVE | RESPONSIBLE | UNDERSTANDING | SENSE OF HUMOR | PATIENT |
| OTHER | | | | |

Please use the chart below to describe your use of drugs. Complete the "yes" or "no" lines for each drug listed, and if "yes", answer the remaining questions on the line.

	No, I Never Used	Yes, I Used	If yes, age at first use	When using, frequency of use (daily, weekly, etc.)	How long since last used?
Tobacco					
Alcohol					
Marijuana/Hashish					
Cocaine					
Crack					
Crank					
Meth/Amphetamine/Speed					
Hallucinogens (LSD, Mushrooms, etc.)					
Coffee					
Other					

Please add any additional information which you feel may be helpful to us: _____

THANK YOU FOR FILLING OUT THIS FORM