



**Personal Identification**

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

Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Referred By: \_\_\_\_\_

Marital Status:

Single: \_\_\_\_\_ Engaged: \_\_\_\_\_ Married: \_\_\_\_\_ Separated: \_\_\_\_\_ Divorced: \_\_\_\_\_ Widowed: \_\_\_\_\_

Education (last year completed): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Position: \_\_\_\_\_ Years: \_\_\_\_\_

**Spiritual**

Denominational preference: \_\_\_\_\_

Church attending: \_\_\_\_\_ Member: \_\_\_\_\_

Church attendance per month (circle): 0 1 2 3 4 5 6 7 8+

Do you believe in God: \_\_\_\_\_ Do you pray: \_\_\_\_\_ Would you say that you are a Christian: \_\_\_\_\_,

Or still in the process of becoming a Christian: \_\_\_\_\_

Have you ever been baptized: \_\_\_\_\_

How often do you read the Bible: Never: \_\_\_\_\_ Occasionally: \_\_\_\_\_ Often: \_\_\_\_\_ Daily: \_\_\_\_\_

Explain any recent changes in your religious life: \_\_\_\_\_

\_\_\_\_\_

## Marriage and Family

Spouse: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Age: \_\_\_\_\_ Occupation: \_\_\_\_\_ How Long Employed: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Date of Marriage: \_\_\_\_\_ Length of Dating: \_\_\_\_\_

Give a brief statement of circumstances of meeting and dating: \_\_\_\_\_

Have either of you been previously married: \_\_\_\_\_ To Whom: \_\_\_\_\_

Have you ever been separated: \_\_\_\_\_ Filed for divorce: \_\_\_\_\_

Information about Children:

Name:	Age:	Sex:	Living:	Year Ed.:	Step-Child:
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_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Describe relationship to your father: \_\_\_\_\_

Describe relationship to your mother: \_\_\_\_\_

Number of sibling(s): \_\_\_\_\_ Your sibling order: \_\_\_\_\_

Did you live with anyone other than parents: \_\_\_\_\_

Are your parents living: \_\_\_\_\_ Do they live locally: \_\_\_\_\_

## Health

Describe your health: \_\_\_\_\_

\_\_\_\_\_

Do you have any chronic conditions: \_\_\_\_\_ What: \_\_\_\_\_

List important illnesses and injuries or handicaps: \_\_\_\_\_

\_\_\_\_\_

Date of last medical exam: \_\_\_\_\_ Report: \_\_\_\_\_

Physician's name and address: \_\_\_\_\_

Current medication(s) and dosage: \_\_\_\_\_

\_\_\_\_\_

Have you ever-used drugs for anything other than medical purposes: \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Have you ever been arrested: \_\_\_\_\_

Do you drink alcoholic beverages: \_\_\_\_\_ If so, how frequently and how much: \_\_\_\_\_

\_\_\_\_\_

Do you drink coffee: \_\_\_\_\_ How much: \_\_\_\_\_ Other caffeine drinks: \_\_\_\_\_

\_\_\_\_\_ How much: \_\_\_\_\_

Do you smoke: \_\_\_\_\_ What: \_\_\_\_\_ Frequency: \_\_\_\_\_

Have you ever had interpersonal problems on the job: \_\_\_\_\_

\_\_\_\_\_

Have you ever had a severe emotional upset: \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Have you ever seen a psychiatrist or counselor: \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Are you willing to sign a release of information form so that your counselor may write for social, psychiatric, or other medical records: \_\_\_\_\_

## Problem Check List

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Anger               | <input type="checkbox"/> Depression    | <input type="checkbox"/> Loneliness    |
| <input type="checkbox"/> Anxiety             | <input type="checkbox"/> Drunkenness   | <input type="checkbox"/> Lust          |
| <input type="checkbox"/> Apathy              | <input type="checkbox"/> Envy          | <input type="checkbox"/> Memory        |
| <input type="checkbox"/> Appetite            | <input type="checkbox"/> Fear          | <input type="checkbox"/> Moodiness     |
| <input type="checkbox"/> Bitterness          | <input type="checkbox"/> Finances      | <input type="checkbox"/> Perfectionism |
| <input type="checkbox"/> Change in lifestyle | <input type="checkbox"/> Gluttony      | <input type="checkbox"/> Rebellion     |
| <input type="checkbox"/> Children            | <input type="checkbox"/> Guilt         | <input type="checkbox"/> Sex           |
| <input type="checkbox"/> Communication       | <input type="checkbox"/> Health        | <input type="checkbox"/> Sleep         |
| <input type="checkbox"/> Conflict (fights)   | <input type="checkbox"/> Homosexuality | <input type="checkbox"/> Wife abuse    |
| <input type="checkbox"/> Deception           | <input type="checkbox"/> Impotence     | <input type="checkbox"/> A Vice        |
| <input type="checkbox"/> Decision Making     | <input type="checkbox"/> In-laws       | <input type="checkbox"/> Other         |

## Briefly Answer The Following Questions

1. What is your problem (what brings you here)?
  
  
  
  
  
  
  
  
  
  
2. What have you done about the problem?
  
  
  
  
  
  
  
  
  
  
3. What are your expectations from counseling?
  
  
  
  
  
  
  
  
  
  
4. Is there any other information that we should know?

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