PERSONAL DATA INFORMATION

Please fill in the following information:

IDENTIFICATION DATA

Date:____

Name:____

Phone(Home)_____________________________Cell_____________________________________

Email Address:____

Address:____

City:____________________________________State___________________Zip_______________

Occupation____

Sex (M)_______(F)___________Birthdate_____________________Age______________________

Referred here by____

Education (Last year you completed)____(Grade/Degree)

Other training (list type and years—including any degree(s)

____

____

HEALTH INFORMATION

Rate your health (check): Very Good_____ Good ____ Average____ Declining____ Other__________

Height___________ Approximate weight______lbs... Weight changes recently: (+/-) _______________

List all important present or past illnesses or injuries or handicaps:____

____

Your physician___________________________Address____

Date of last medical examination_________________Report_____________________________________

Are you presently taking medication: Yes_________ No___________?

If yes, please list the medication(s) and what it treats:____
____

Have you used drugs for other than medical purposes? Yes _______No________

What?____

Have you thought of committing suicide? Yes_________ No______ When? _______________________

Have you ever been arrested? Yes______ No_______ When? ___________________________________

Have you recently suffered from the loss of someone who was close to you? Yes _________No________

Explain:____
____

Please answer the following questions. Use as much space and write as much as you are comfortable explaining. The more information that I know ahead of time, the less time will be needed and the more our thoughts can be organized.

What brings you here? Please be specific about the problems you are experiencing.

What have you done about this situation?

What are your expectations in coming here? What do you want me to do?

Is there any other information I should know?

MARRIAGE AND FAMILY INFORMATION

Marital Status: Single ______In a relationship _____Engaged _____Married ______Separated_____
Divorced _______Widowed______

If you are presently married or in a relationship:

Are they aware of you seeking counseling? Yes___ No_____

How long have you been in this relationship/marriage? _________

Do you feel couples therapy would be beneficial at this time? Yes____ No ______

INFORMATION ABOUT CHILDREN

Name	Age	Sex	Education	Marital Status	Personality/Character	Living

RELIGIOUS BACKGROUND

Denominational Preference:____

Do you consider yourself a religious person? Yes _____ No ______ Uncertain _______

Explain recent changes in your religious life, if any:

____
____

PERSONALITY INFORMATION

Have you undergone any kind of counseling before? Yes______ No ________

If yes, list counselor/psychologist/psychiatrist/ therapist and dates:

____
____

Was it beneficial? ____________ If not, why?
____
____

What, if anything do you fear? ____

Have you recently suffered a loss from serious social, business or other personal loss, etc.?

Yes _____ No ______ If yes, please explain:

____
____

Circle any of the following works which best describe you now:

Godly	Ethical	Hypocritical	Strict	Angry	Unreasonable	Abusive
Irresponsible	Cruel	Uneducated	Proud	Embarrassed	Ambitious	Active
Self-Confident	Persistent	Nervous	Hardworking	Impatient	Impulsive	Moody
Often-Blue	Likeable	Excitable	Imaginative	Calm	Sensitive	Serious
Easy-going	Shy	Good-natured	Introvert	Extrovert	Leader	Quiet
Hard-boiled	Submissive	Lonely	Self-conscious	Humorous	Sloppy	Whiner
Selfish	Lots of friends	Failure	Success	Self-disciplined		

Are there other words that would help you to describe yourself? ______________________________

Circle the words that best describe why you are seeking counseling:

Grief	Suicidal Thoughts	Loss of faith in God	Guilt	Other: _______
Anxiety	Relationship with Children	Anger with God	Anger	
Depression	Relationship issues	Nervousness	Worry	
Loneliness	Loss of self-respect	Homosexuality	Loss of hope	
Loss of love	Nervousness	Sexual Coldness	Religious doubts	
Fear	Marriage Problems	Loss of faith in others	Religious fears	
Loneliness	Sexual Concerns	Self-Doubt	Substance Abuse	

TELEVISION/ENTERTAINMENT

How much television do you watch every day? ____________ Hours

What are your favorite programs? ____

What is your favorite type of music/entertainers?____

BIO-PSYCHOLOGICAL INFORMATION

Have you ever felt people were watching you?	Yes ___	No ___
Do people's faces ever seem distorted?	Yes___	No ___
Do you ever have difficulty distinguishing faces?	Yes ___	No ___
Do you feel someone has something against you?	Yes ___	No ___

Are you plagued by fears? Yes ___ No ___

Do you hear voices? Yes ___ No ___

PERSONAL BEHAVIORAL HABITS

Do you drink coffee or other caffeinated drinks? Yes ___ No ___ How much/day? _____

Do you smoke? Yes ___ No ___ How much/day? _____

Do you explode when you get angry? Yes ___ No ___

Do you withdraw when you get angry or hurt? Yes ___ No ___

Do you frequently argue with other people? Yes ___ No ___

Do you drink alcohol? Yes ___ No ___ How much/day? _____

Do you use drugs? Yes ___ No ___ What kind/how much?

____