GENERAL INFORMATION **PLEASE PRINT CLEARLY**

Name____ Birthdate____________________ Gender M/F

Address____ Social Security #______-______-________

City______________________________ State_______ Zip________ Home Phone_________________________

Is this the address where billing should be sent? Y/N Cell Phone_________________________

If yes, list billing address____

Person to contact in an emergency____________________________________ Phone______________________

Address____ Relationship to you__________________

List the persons with whom you are now living and their relationship to you (*include ages of children)*_______

____

____

Occupation____ Education Level______________________

Employer____ Work Phone_____________________

Address____

Length of current employment____

Spouse's name__________________________ Birthdate_______________ Social Security #_____-____-______

Spouse's occupation_________________________ Spouse's Education Level__________________________

Spouse's employer____ Work phone____________________

Address____

Religious preference____________________ Referred by: *(circle one)* pastor, attorney, physician, relative, former/other client, friend, Yellow Pages, other____

Name of referring person/party____

Address of referring party____

Phone # of referring party__________________________ Comments___________________________________

____

_ _

(This section to be completed by the psychologist only)

Date first seen__________________________ Counseling fee______________________________

DSM #______________________________________ ____________________________________

CONFIDENTIAL INFORMATION

PROBLEM INFORMATION FOR COUNSELOR

Briefly describe your chief concern

____
____
____
____

Briefly describe the history and development of your concern from onset to present

____
____
____
____

Current stressors *(please describe* ***how*** *the following areas are stressful):*

Marriage and home____

Children/parents____

Work/school____

Financial____

Social____

Spiritual____

Other____

Major present stress____

Rate how strongly you want to change your present problem on the scale below:

(do not want to change) 1 2 3 4 5 6 7 8 9 10 *(desperately desire change)*

In general, do you feel reasonably comfortable seeking counseling? Yes_____ No_____

Identify any *specific* concerns or anxieties you have about counseling

____
____

What are your goals for counseling *(be as specific as possible)*

____
____
____

Previous counseling?_______ When?__________________ By whom?____________________________

How helpful was previous counseling?

____

FAMILY BACKGROUND

Father's name________________________________ If deceased, date and cause___________________________

Age________ Occupation_____________________ Education level_______________ Health_________________

Describe his personality, attitude and relationship to you, past and present

____

____

Mother's name________________________________ If deceased, date and cause___________________________

Age________ Occupation_____________________ Education level_______________ Health_________________

Describe her personality, attitude and relationship to you, past and present

____

____

Parent's marital status__________________________ Briefly describe your parents' marriage

____

____

How did they handle conflict in their relationship?

____

____

If divorced, when did it occur and what was your reaction to it?

____

____

If one or both parents remarried, give date(s) and your reaction

____

____

Step-mother's name_____________________________ Age_______ Occupation____________________________

Step-father's name______________________________ Age_______ Occupation____________________________

Education level________________________ Health______________

Describe their personality, attitude and relationship to you, past and present

____

____

If you were not brought up by your parents, who raised you?

____

____

Between what years?__________________ Who cared for you as an infant?________________________________

Who disciplined you as a child and how?

____

____

Brothers and sisters *(list names, ages, marital status, occupations and places of residence)*

____

Give your impression of the home atmosphere in which you grew up, including how compatible you all were with each other

____

As you were growing up, how was love expressed in your home?

____

How was anger expressed?

____

What were your parents' attitudes about sex and was there any discussion of or instruction about sexuality in the home?

____

Were you or your siblings ever physically and/or sexually abused, assaulted or neglected?

____

MARITAL HISTORY

Marital status_______________ How long did you know your spouse before engagement?______________________

Length of engagement________________________________ Date of marriage_________________________________

Describe the strengths of your marital relationship

____

Describe the areas of conflict in your relationship

____

Describe your relationship with your in-laws

____

List names and ages of your children/step/foster children or other dependents and indicate which *(if any)* are from a previous relationship:

____
____
____

Dates of previous marriages/divorces

____
____
____

RELIGIOUS ORIENTATION (IF APPLICABLE)

Describe the religious training you received while growing up and how God was viewed by your family

____
____
____

Denominational preference ______________________________Average monthly worship attendance___________

How would you describe your current spiritual life?

____
____
____

HEALTH/MEDICAL INFORMATION

Present health status (circle one): Excellent Good Fair Poor

What serious illnesses have you had and when?

____
____
____

Hospitalizations *(reason/diagnosis/dates)*

____
____
____

Medications currently taken and their purpose *(include non-prescription medications, e.g. sleeping pills, diet pills, etc.)*

MEDICATION/PURPOSE	DOSAGE
____	______________________________
____	______________________________
____	______________________________
____	______________________________
Prescribed by______________________________	______________________________

Current symptoms *(Please circle any that apply to you):*

Headaches, dizziness, fainting spells, anxiety, stomach trouble, loss of appetite, bowel disturbances, recent weight gain or loss, fatigue, sleep disturbances, racing thoughts, nightmares, alcoholism, drugs, use of sedatives, dislike of weekends or vacations, feelings of lonliness, depression, obsession, inability to relax or have a good time, feelings of worthlessness or hopelessness, suicidal thoughts/feelings, shyness, inability to make friends, excessive ambition, indecisiveness, distractibility, inability to focus, persistent fears, financial concerns, sexual issues, recurrent troubling thoughts, grieving, bad home conditions, feelings of inferiority, moodiness, outbursts of anger, other ____

List any current or past history of alcoholism or drug addiction for you or any family member

____

____

____

List any current or past history of nervous or emotional disorder for you or any family member

____

____

____

____

Completed by: ____ Date: ____________________________

Please bring this completed form to your first session. This will help your counselor to help you. Thank you!

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