

Real Life Counseling
"Search me, O God, and Know my Heart"

COUNSELING INFORMATION
(ALL INFORMATION IS PRIVATE & CONFIDENTIAL)

I - General Information

Name: _____ Date: _____

Birth Date: _____ Age: _____

If Under 18, Please give Parent's or Guardian's Name: _____

Current Address: _____

Street

City	State	Zip
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Home Phone: _____ Work: _____

Cell/Beeper: _____ Best #: _____

Employer: _____ How long at Present Job? _____

Marital Status: _____ Spouse's Name: _____ Spouse's Age: _____

Years Married: _____ Spouse's Occupation: _____

Previous Marriages: Yes ___ No ___ If Yes, How many times have you been Married? _____

Children's Names	Age	Sex	Relation	At Home	School Grade
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Who Referred you to this Office? _____

II - Medical Concerns

Family Physician: _____ Date of Last Physical: _____

Address: _____

Street

City	State	Zip
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Phone Number: _____ Fax: _____

II

Please List All Current Prescribed Medications:

Please List All Vitamins, Herbals, Homeopathic or Over the Counter Medicines that you take Regularly: _____

Please List All Major or Chronic Illnesses: _____

Hospitalizations (Medical &/or Psychiatric): _____

Current Medical Problems & Symptoms: _____

Family Members who have had Medical/Psychological Problems: _____

III - Counseling Concerns

Previous Counseling: Yes ___ No ___ Type of Counseling: _____

Reason for Past Counseling & for How Long? _____

Briefly Describe your Reasons for Seeking Counseling at this Time: _____

Please Indicate the Severity of your Problems on the Scale Below:

Mild _____ Moderate _____ Severe _____ Extremely Severe _____ Incapacitating _____

Describe Significant Events Surrounding or Leading up to the Problem: _____

What Solutions have you Tried or Considered Trying? _____

III

Please Circle Any of the Following that Applied to you as you were Growing up:

Happy Childhood	School Problems	Medical Problems	Sexual Abuse
Unhappy Childhood	Family Problems	Substance Abuse	Physical Abuse
Emotional Problems	Behavioral Problems	Legal Problems	

Others Not Listed Above: _____

Please Describe: _____

Do you have Strong Religious Convictions: Yes___ No___ If Yes, What is your Faith Tradition:

Have you Ever Thought about Suicide? Yes___ No___

Have you Ever Attempted Suicide? Yes___ No___ If Yes, When & How?

Counselor: _____

Date: _____