



Adult Couselee Information Form

Each individual participating in counseling is asked to complete this form as this will expedite the process. This information will remain confidential.

Date: _____

Client Name: _____ DOB: ____/____/____ Age: _____

Spouse's Name: _____ DOB: ____/____/____ Age: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Employed at: _____ Work Address: _____

Religious Background: _____ Gender: Male Female

Emergency Contact Name: _____ Phone #: _____

How did you hear about us? _____ Referred by: _____

Are you Currently Involved in Church? Yes No If yes, indicate where you attend church and how frequently: _____

Father's Name: _____ Age _____ Mother's Name: _____ Age _____

Was your childhood: Sad? Happy? Lonely? Rejected? Good? Other?

Names & Ages of Brothers & Sisters - Please include yourself, and any half brothers and sisters names.

- 1. _____ Age _____ 4. _____ Age _____
- 2. _____ Age _____ 5. _____ Age _____
- 3. _____ Age _____ 6. _____ Age _____

Relationship Status: Single Married Divorced Widowed Separated Living with Someone

Family: Do you have children? Yes No If yes, provide information below and designate step-children as ("Step"):

- 1. _____ Age _____ 4. _____ Age _____
- 2. _____ Age _____ 5. _____ Age _____
- 3. _____ Age _____ 6. _____ Age _____

Education: GED H.S. Diploma Associate's/Technical Degree Bachelor's Degree Post-Graduate Degree Other

Employment Status: Full-time Part-time Unemployed Homemaker Retired Student

Medical History: Do you have any significant health/medical issues? Yes No If yes, what is/are the health issue(s) and are you limited in any way? _____

Have you attended counseling previously? Yes No When: (specify dates) _____

Name of Counselor(s): _____ Presenting Issues at that Time: _____

Are you currently taking any psychotropic medications? No Yes (Please list): _____

Suicide Risk: Are you currently suicidal? Yes No Have you ever thought about or tried to hurt yourself? Yes No If yes, what were the circumstances at the time? _____

Has anyone close to you ever committed suicide? Yes No If yes, who, how, and when: _____

Abuse History: Have you ever had any previous trauma? (Physical, emotional, sexual, abortion, etc.) Yes No If yes, briefly explain (who, what and when): _____



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Overall, how would you characterize yourself, check those that apply:

- Happy Defeated Guilt-ridden Tearful Sad Suicidal Depressed Angry
- Satisfied Anxious Hurt Bitter Numb Insecure Lonely _____

Check the following symptoms that you have experienced in the last 30 days:

- Anger Hopelessness Racing Thoughts Withdrawal
- Depression Panic Attacks Change in Appetite/Weight Arguing
- Anxiety Fear Sleep Difficulties Increased Alcohol Use
- Extreme Mood Swings Guilt Crying Spells Aggressive Behavior
- Irritability Lack of Emotions Frequent Headaches Distracted/Disorganized
- Worry Problems Concentrating Hyperactivity Self-Injury
- Decreased Sex Drive Memory Problems Impulsivity Avoiding School or Job
- Frustration Difficulty Making Decisions Binge Eating Other: _____
- Helplessness Distractibility Induced Vomiting _____

Support Systems: Do you have people that you can turn to for support? Yes No If yes, who? _____

Have you made Jesus Christ your personal Lord and Savior? Yes No Unsure

Are you satisfied with your personal faith? Yes No Unsure Comments: _____

Strengths: What do you feel are your strengths? _____

Presenting Issues: Briefly explain why you are seeking counseling at this time: _____

Goals: What do you hope to achieve through counseling? _____

In the past 12 months, which of these has happened to you?

- | | | |
|--|--|--|
| Death of spouse..... <input type="checkbox"/> | Vacation..... <input type="checkbox"/> | Change in living conditions..... <input type="checkbox"/> |
| Divorce..... <input type="checkbox"/> | Addition to family..... <input type="checkbox"/> | Revision of personal habits..... <input type="checkbox"/> |
| Marital separation..... <input type="checkbox"/> | Business readjustment..... <input type="checkbox"/> | Trouble with boss..... <input type="checkbox"/> |
| Jail term..... <input type="checkbox"/> | Change of financial status..... <input type="checkbox"/> | Change in work hours, conditions..... <input type="checkbox"/> |
| Death of close family member..... <input type="checkbox"/> | Death of close friend..... <input type="checkbox"/> | Change in residence..... <input type="checkbox"/> |
| Personal injury or illness..... <input type="checkbox"/> | Change in # of marital arguments..... <input type="checkbox"/> | Change in schools..... <input type="checkbox"/> |
| Marriage..... <input type="checkbox"/> | Mortgage of loan over \$10,000..... <input type="checkbox"/> | Change in recreational habits..... <input type="checkbox"/> |
| Fired from work..... <input type="checkbox"/> | Foreclosure of mortgage or loan..... <input type="checkbox"/> | Change in church activities..... <input type="checkbox"/> |
| Marital reconciliation..... <input type="checkbox"/> | Change in work responsibilities..... <input type="checkbox"/> | Change in social activities..... <input type="checkbox"/> |
| Retirement..... <input type="checkbox"/> | Son or daughter leaving home..... <input type="checkbox"/> | Mortgage of loan under \$10,000..... <input type="checkbox"/> |
| Change in family member's health..... <input type="checkbox"/> | Trouble with in-laws..... <input type="checkbox"/> | Change in sleeping habits..... <input type="checkbox"/> |
| Pregnancy..... <input type="checkbox"/> | Outstanding personal achievement..... <input type="checkbox"/> | Change in # of family gatherings..... <input type="checkbox"/> |
| Sex difficulties..... <input type="checkbox"/> | Spouse begins or ends work..... <input type="checkbox"/> | Christmas season..... <input type="checkbox"/> |
| Change in eating habits..... <input type="checkbox"/> | Starting of finishing school..... <input type="checkbox"/> | Minor Violation of the law..... <input type="checkbox"/> |