PRACTICAL CHRISTIAN COUNSELING

PERSONAL HISTORY

Client's name: _____Date: ____/____ / _____

Gender: ___F ___M Date of birth: ____/____ /_____ Age:_____

Form completed by (if someone other than client):_____

Address: _____ City: _____State: _____ Zip: _____

Phone (home): _____ (work): _____ ext: _____

Emergency contact name: _____ Phone: _____

Do you have insurance coverage for counseling? Yes No Insurance Co: _____

Policy #: _____ Group #: _____ Plan code _____

Are you the policy holder? Yes No Have you met your deductible? Yes No Unsure

Name, DOB, and SSN of policy holder: _____

If you need any more space for any of the questions please use the back of the sheet.

Please describe the problems or issues for which counseling is sought – give as much detail as possible:

What are your goals for counseling?:

Do you feel suicidal at this time? ___Yes ___No
If Yes, explain:

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Family Information

			Living		Living with you	
Relationship	Name	Age	Yes	No	Yes	No
Mother						
Father						
Spouse						
Child						
Child						
Child						
Child						
Child						

Significant others (e.g., brothers, sisters, grandparents, step-relatives, half-relatives. Please specify relationship.

			Living		Living with you	
Relationship	Name	Age	Yes	No	Yes	No

Marital Status (more than one answer may apply)

____Single ____Divorce in process (Length of time: _____)

____Unmarried, living together (Length of time: _____) ____Legally married (Length of time: _____)

____Separated (Length of time: _____) ____Divorced (Length of time: _____)

____Widowed (Length of time: _____) ____Annulment (Length of time:_____)

Total number of marriages: _____

Assessment of current relationship (if applicable): ____Good ____Fair ____Poor

Parental Information

____Parents legally married ____Mother remarried: Number of times: _____

____Parents have ever been separated ____Father remarried: Number of times: _____

____Parents ever divorced

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.):

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Development

Are there special, unusual, or traumatic circumstances that affected your development? ____Yes ____No

If Yes, please describe:_____

Has there been history of child abuse? ____Yes ____No

If Yes, which type(s)? ____Sexual ____Physical ____Verbal

If Yes, the abuse was as a: ____Victim ____Perpetrator

Other childhood issues: ____Neglect ____Inadequate nutrition

Other (please specify): _____

Comments re: childhood development:

Social Relationships

Check how you generally get along with other people: (check all that apply)

____Affectionate ____Aggressive ____Avoidant ____Fight/argue often

____Follower ____Friendly ____Leader ____Outgoing

____Shy/withdrawn ____Submissive ____Other (specify):_____

Sexual orientation: _____Comments: _____

Sexual dysfunctions? ____Yes ____No

If Yes, describe: _____

Any current or history of being a sexual perpetrator? ____Yes ____No

If Yes, describe: _____

Cultural/Ethnic

To which cultural or ethnic group(s), do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? ____Yes ____No

If Yes, describe: _____

Other cultural/ethnic information: _____

Spiritual/Religious

How important to you are spiritual matters? ____Not ____Little ____Moderate ____Much

Are you affiliated with a spiritual or religious group? ____Yes ____No

If Yes, describe: _____

Were you raised within a spiritual or religious group? ____Yes ____No

If Yes, describe: _____

Would you like your spiritual/religious beliefs incorporated into the counseling? ____Yes ____No

If Yes, describe: _____

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Education

Years of education: _____ Currently enrolled in school? ___Yes ___No

___ High school grad/GED

___ Vocational: Number of years: ____ Graduated: ___Yes ___No Major: _____

___College: Number of years: ____ Graduated: ___Yes ___ No Major: _____

___Graduate: Number of years: ____ Graduated: ___Yes ___ No Major: _____

___Other training:

Employment

Begin with most recent job, list job history:

Employer Dates Title Reason left the job How often miss work?

_____

_____

_____

_____

Currently: ___Full time ___Part time ___Temp ___ Laid-off ___Disabled ___ Retired

___ Student ___Other (describe): _____

Military

Military experience? ___Yes ___No Combat experience? ___Yes ___No

Where: _____

Branch:_____ Date enlisted: _____

Date discharged: _____ Type of discharge: _____

Rank at discharge: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity How often now? How often in the past?

_____

_____

_____

_____

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Medical/Physical Health

List any current health concerns:

List any recent health or physical changes:

List current medications, purpose, how long you have been taking them and side effects you are experiencing:

Chemical Use History

	Method, Amount & Frequency of use	Age of first use	Age of last use	Used in last 48 hrs		Used in last 30 days	
				Yes	No	Yes	No
Alcohol							
Barbiturates							
Cocaine/Crack							
Heroin/Opiates							
Marijuana							
PCP/LSD/Mescaline							
Inhalants							
Caffeine							
Nicotine							
Other:							
Other:							

Substance(s) of preference:

Substance Abuse Questions

Describe when and where you typically use substances:

Describe any changes in your use patterns:

Describe how your use has affected your family or friends (include their perceptions of your use):

Reason(s) for use: ___Addicted ___Build confidence ___Escape ___Self-medication ___Socialization

___Taste ___Other (specify):

How do you believe your substance use affects your life?

Who or what has helped you in stopping or limiting your use?

Does/Has someone in your family present/past have/had a problem with drugs or alcohol? ___Yes ___No

If Yes, describe:

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Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ___Yes ___No

If Yes, describe:

Have you had adverse reactions or overdose to drugs or alcohol? (describe):

Have drugs or alcohol created a problem for your job? ___Yes ___No

If Yes, describe:

Counseling/Prior Treatment History

*Information about **client** (past and present):*

Previous counseling, treatment, psychiatric hospitalizations	When	Where	Your reaction to overall experience

Previous suicide attempt(s): ___Yes ___ No

If Yes, describe:

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

___Aggression
___Alcohol dependence
___Anger
___Antisocial behavior
___Anxiety
___Avoiding people
___Chest pain
___Cyber addiction
___Depression
___Disorientation
___Distractibility
___Dizziness
___Drug dependence
___Eating disorder
___Elevated mood
___Fatigue
___Gambling
___Hallucinations
___Heart palpitations
___High blood pressure
___Hopelessness
___Impulsivity
___Irritability
___Judgment errors
___Loneliness
___Memory impairment
___Mood shifts
___Panic attacks
___Phobias/fears
___Recurring thoughts
___Sexual addiction
___Sexual difficulties
___Sick often
___Sleeping problems
___Speech problems
___Suicidal thoughts
___Thoughts disorganized
___Trembling
___Withdrawing
___Worrying
___Other (specify): _____
_____

Briefly discuss how the above symptoms impair your ability to function effectively: