COUNSELING PROFILE FORM

Name: _____ Today's Date: _____

Sex: □ Male □ Female Date of Birth: _____ Age: _____

Do you regularly attend a church, synagogue, or other religious institution? □ Yes □ No. If yes, which one?_____

What is your current occupation? _____

What is your level of satisfaction with your occupation?_____

What is your highest level of education?_____

RELATIONAL INFORMATION

Current relational status: □ Single □ Committed Relationship □ Engaged □ Married □ Separated □ Divorced □ Widowed
If in a relationship; living together, engaged, married, separated, divorced, or widowed, for how long? _____
Number of previous marriages for you? _____ For your partner? _____
If applicable what is your partner's name: _____ Age: _____
Is your partner supportive of you seeking counseling? □ Yes □ No □ Unsure □ Partner doesn't know

Please list your children (including step, adopted, foster) below:				
Name	Sex	Age or yr. of death	Relationship to you	Living with whom?

Who else lives with you? _____

Please list your father, mother, sisters, brothers, stepfamily relations, or other family members who had a significant effect on your life (either positive or negative). (Use the back of this sheet if necessary.)

Name	Sex	Age or yr. Of Death	Relationship to you	Describe him/her

COUNSELING HISTORY

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the names of the therapists or programs. (Use the back if necessary.)

Therapist's Name or Program	Major Issue	Dates

Has anyone in your family ever been treated or hospitalized for substance abuse, mental health issues, or psychiatric conditions?
□ Yes □ No
If yes, please describe: _____

Have any of your family members or friends ever attempted or committed suicide?
□ Yes □ No
If yes, who and when: _____

MEDICAL HISTORY
Please list any conditions, illnesses, treatments, or surgeries that might be relevant to your reason for seeking counseling:

_____

Are you currently receiving any traditional or non-traditional medical treatment? □ Yes □ No If yes, please describe and note

providers: _____

Please list all current medications you are taking and the reasons for taking them. (List even if you seldom use, or take only as needed.)		
Name of medications	Dose	Reason for taking

Are you taking these medications according to the doctor's recommendations? □ Yes □ No If no, please explain on back.

Prescribing Doctor:_____ Date and outcome of last physical exam: _____

PRESENT ISSUES AND GOALS

Check any of the following symptoms or problems that you currently are or recently have experienced:

□ Stress	□ Marital Problems	□ Seeing Things Others Don't
□ Anxiety	□ Other Relational Problems	□ Hearing Voices
□ Panic	□ Physical Abuse	□ Racing Thoughts
□ Depression	□ Emotional Abuse	□ Eating Problems
□ Apathy	□ Verbal Abuse	□ Drug Use
□ Fatigue/Lack of Energy	□ Sexual Abuse	□ Alcohol Use
□ Loss of Appetite/Overeating	□ Sexual Problems	□ Pregnancy
□ Trouble Sleeping	□ Gender Identity Issues	□ Abortion
□ Poor Concentration	□ Anger	□ Legal Matters
□ Feeling Worthless	□ Aggressive Behavior	□ Work Stress
□ Recent Death	□ Bad Dreams	□ Career Choices
□ Grief	□ Unwanted Memories	□ Indecisiveness
□ Chronic Pain	□ Loss of Control	□ Parenting Problems
□ Loneliness	□ Impulsive Behavior	□ Financial Problems
□ Fears	□ Compulsive Behaviors	□ Spiritual Problems
□ Shyness	□ Controlled by Others	□ Other
□ Low Self-Esteem	□ Obsessive Thoughts	_____

Please use an "X" on the scale below to indicate how distressing your problem(s) are to you.

[----------]

Very Minimally Distressed — Moderately Distresed — Very Extremely Distressed

Are you currently experiencing any suicidal thoughts? □ Yes □ No
Have you experienced suicidal thoughts in the past? □ Yes □ No
Have you attempted suicide in the past? □ Yes □ No
Are you currently experiencing any violent or homicidal thoughts? □ Yes □ No

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INTENT FOR THERAPY

Please write a 2-3 paragraph summary of the issues you want to work on. Why are you seeking counseling and what are your goals? (Use the back of this page). In the instance of Couples/Family Therapy, BEFORE submitting these forms to Gretchen, SHARE this summary with your partner/family.