



# PERSONAL INFORMATION FORM

Today's Date: \_\_\_\_\_

(Please print clearly)

**THANK YOU** for taking the time to fill out this information sheet. Your counselor will use this to best assist you in your counseling work. We will maintain your strict confidence regarding this information, subject to the exceptions noted in the Client Consent for Pastoral Counseling form.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (hm) \_\_\_\_\_ (wk) \_\_\_\_\_ (cell) \_\_\_\_\_ Email: \_\_\_\_\_

Do we have your permission to: Call?  Yes  No Do we have your permission to leave a message?  Yes  No

Best number & time to call \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Employed? Yes  No  Where: \_\_\_\_\_

Who referred you to us? (Name & Relationship) \_\_\_\_\_

Current Relationship Status:  Single  Engaged  Married (1<sup>st</sup> marriage? Y N )  Separated  Divorced

List name, birth date, sex, relationship of all children and whether they live at home with you:

Name	DOB	Age	Sex	Biological or Step	At Home

What is the problem or issue that led you to seek counsel? \_\_\_\_\_

How long have you experienced this problem? \_\_\_\_\_

Have you seen a pastor, counselor or psychiatrist before? Yes  No  If yes, please complete the following:

Name: \_\_\_\_\_ When: \_\_\_\_\_ Reason: \_\_\_\_\_

Name: \_\_\_\_\_ When: \_\_\_\_\_ Reason: \_\_\_\_\_

Are you currently seeing a pastor, counselor or psychiatrist for this problem or another? Yes  No

If yes, who are you currently seeing? \_\_\_\_\_

Are you presently taking any prescription medication? Yes  No  If yes, list below. (Use back if necessary.)

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Purpose: \_\_\_\_\_ Physician: \_\_\_\_\_

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Any problems with:  Eating  Sleeping  Recent weight changes

Have you ever thought about harming yourself? Yes  No  If yes, how recently? \_\_\_\_\_

Any past hospitalizations related to mental health, attempted suicide, or alcohol or substance use? Yes  No

If yes, please explain: \_\_\_\_\_

Has anyone in your family committed suicide, been treated for alcohol or substance abuse or received treatment for mental or emotional problems? Yes  No  If yes, please state who and describe: \_\_\_\_\_

Describe your relationship with God:  Close  Distant  Unsure

Church Member: Yes  No  What Church? \_\_\_\_\_ Church Attendance:  Rarely  Sometimes  Regularly

How did you hear about us? \_\_\_\_\_

Having read and completed the above, I declare that the information I have given is correct and complete, to the best of my ability:

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_