Information Form

To help with your first session, please fill out the following information as completely as you can.

Date _______________ **Age** _______________ **Birthdate** _______________

Name ____
First Middle Last

Address ____
Street City State Zip

Home Phone Number (_____)_________________ **E-Mail Address** _____________________________

Employer Name/Occupation _________________________________(_____)_________________
Phone Number

Social Security Number _________________________ **Marital Status** _________________________

Referred By ____
Name Relationship

Person responsible for the bill: **same as above or**

Name ____
Relationship

Address ____
Street City State Zip

Phone Number (_____)_________________

Emergency Contact

Name ____
Relationship

Address ____
Street City State Zip

Phone Number (_____)_________________

Church Membership____

How often do you participate in some type of religious activity? _______________________________

____

____

Briefly describe your spiritual life. ______________________________

____

____

List all members of the family (including anyone living in the house) by name and their age:

1. ______________________________
Name **Age** **Relationship**

2. ______________________________
Name **Age** **Relationship**

3. ______________________________
Name **Age** **Relationship**

4. ______________________________
Name **Age** **Relationship**

5. ______________________________
Name **Age** **Relationship**

6. ______________________________
Name **Age** **Relationship**

Have you ever had counseling before? ☐ **yes** ☐ **no**

If yes, describe and list counselor. ______________________________

____

What do you consider the primary need for counseling at this time? ______________________________

____

____

When did the problem start or when did you first notice it? ______________________________

____

____

Have your eating or sleeping habits changed? ☐ **yes** ☐ **no**

If yes, explain. ______________________________

____

____

What would you like to get out of counseling? ______________________________

____

____

What have you tried so far? ______________________________

____

____

Describe your personality (focus on strengths). ______________________________

____

____

____

____

What physical and/or psychological stressors have occurred in your life within the last year (i.e., moves, separations, deaths, abuse, etc.)? ______________________________

____

____

How do you tend to react to stress? ______________________________

____

____

Medical Information

Are you taking any prescription drugs at this time? ☐ **yes** ☐ **no**

If yes, list them below:

1. ______________________________
Name **Dose** **Frequency** **Indication** **Compliant? (Y/N)**

2. ______________________________
Name **Dose** **Frequency** **Indication** **Compliant? (Y/N)**

3. ______________________________
Name **Dose** **Frequency** **Indication** **Compliant? (Y/N)**

4. ______________________________
Name **Dose** **Frequency** **Indication** **Compliant? (Y/N)**

Prescribing Psychiatrist (if applicable) ______________________ (____)______________
Phone Number

Primary Care Physician ______________________ (____)______________
Phone Number