Christian Perspective
COUNSELING

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____

Describe your spiritual life and the role you would like it to have in your counseling.______________

____

____

____

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

____

List all nuclear family members (including anyone else 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**

______________ ______________ ______________
# of pregnancies **# of live births** **# of living children**

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? ____________________

____

____

Are you current involved in any litigation, an order of protection, or investigation? ☐ **yes** ☐ **no**

If yes, please describe the nature of the legal matter and its current status. ____________________

____

____

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

Health Insurance Information

Name of primary insurance company ____

Address ____
Street City State Zip

Policy/ID/Contract Number ____________________ **Group Number** ____________________

Policy Holder ____
Name Relationship

____________________ ____________________
Birthdate Social Security Number

____
Address

____
Phone Number

Employer ____ **Effective Date:**__________________

I authorize the release of any medical or other information necessary to process claims.

____ ____________
Client or Minor Client's Guardian Date

I authorize payment of medical benefits to Christian Perspective Counseling.

____ ____________
Signature of Policy Holder Date

____ ____________
Signature of Therapist Date