Charleston CHRISTIAN COUNSELING

New Client Information Form

Personal and Family Record

Name:_____ Date:_____

Age: _____Birthday: _____Social Security Number: _____-_____-_____

Address:_____City:_____

State:_____ Zip/Postal Code:_____

Phone (home):_____(cell)_____(work)_____

Employer:_____Occupation:_____

Email Address: _____

In case of emergency, call (person's name):_____

Relationship to you _____ Telephone number _____

Circle last year of school completed: 9 10 11 12 GED College: 1 2 3 4 4+

Other:_____

Marital Status: Single_____ Engaged ____ Married _____ How long?_____

Separated_____ How long?_____ Divorced_____ How long?_____

Widow/er _____ How long? _____

If married, Spouse Name_____

Spouse Occupation _____

If you have children, please list their names, age, and sex. Do they live in the home with you?

_____

_____

_____

Notes:_____

_____

_____

_____

_____

_____

How did you hear about us?

_____Website **_____ Find Christian Counselor.com**

_____Church **_____ Psychology Today.com**

_____ Friend **_____ Other _____**

_____Referral _____

May we contact this person to thank them? ___yes ___no (please note we will only thank them for their recent referral, we will not provide your information)

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Process Notes

Counseling History

Have you ever been to counseling for any reason? Yes_____ No_____

When and for what reason?

_____
_____
_____
_____
_____

How long did you go to counseling? _____

Are you presently working with any other Counselor, Psychologist, or Support Groups?

Yes_____ No_____ If yes, what reason and for how long?

_____
_____
_____
_____

Integration of Faith in Counseling Process

Please check below to describe how important your faith/spirituality is to you in your life:

____ Significant _____ Moderate _____Very little _____Not at all

Please check below your desire for an integration of your faith/spirituality in counseling:

_____ Yes _____ No

Please check below your desire for prayer to be a part of the counseling process:

_____ Yes_____ No

Medical Information

Do you have a physician? Yes_____ No_____ Name_____

Are you taking any prescription drugs? Yes _____ No_____

If yes, please write the medication name and for what purpose you are taking it:

_____
_____
_____
_____
_____

Who prescribed the medications?

_____

How often do you see this doctor?

_____

Describe your physical health: excellent _____ good _____ adequate _____

poor _____

Process Notes

Are you currently having any health problems that you think are significant?

_____

_____

_____

Have you ever had surgery? If yes, for what reason?_____

Have you ever been hospitalized for mental illness or substance abuse? Yes _____ No_____

If yes, for what specific reason?

_____

Are you currently seeing any other medical professionals? (Physical Therapist, Massage Therapist, Acupuncture, Chiropractor, etc.) Yes _____ No_____

Life Circumstances

Please circle any losses you have experienced:

1. Death of:

Spouse Child Father Mother Sister Brother Grandmother Grandfather Friend Other _____

2. Any Below:

Divorce Separation Broken Engagement Miscarriage Abortion Infertility

Bankruptcy Homelessness Career or Job Loss

Other:_____

_____

_____

_____

_____

____

3. In addition, please check any experiences below:

____ Abuse (__mental/emotional __ physical ___sexual)

____ Neglect

____Abandonment

____Adoption

____ Major Illness

____Other Major Trauma, please briefly describe:

_____

_____

_____

_____

_____

_____

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Process Notes

Please check any problems that *concern* you at this time:

Relationship(s) with: ___Spouse ____Children _____Parents _____In-Laws _____ Co-workers ____Friends _____Partners _____Other

General:

_____Eating Problems (Too much or Too little)

_____Depression	_____ Sexual Issues	___Nightmares
_____Anxiety	_____ Sleeping Problems	____ Irritability
_____ Fear	_____ Confusion	___Mood Swings
_____Grief	_____ Impulsivity	
_____Self-Esteem	_____ Lose track of time	
_____Stress	_____ Anger/frustration	
_____Feelings about God	_____ Blackouts	
_____Career	_____ Thoughts racing	
_____Loneliness	_____ Panic Attacks	

In the last few days, have you had suicidal thoughts? ___Yes (specify below)___ No

If YES, answer the following questions:

FREQUENCY: __Rarely __ Sometimes__ Frequently __Always

DURATION: __Seconds __ Minutes __ Hours __ Constant

INTENSITY: __Brief and fleeting __Focused deliberation __Intense rumination

Have you seriously considered attempting suicide in the past? ____Yes (specify below) ___No

If YES, please describe: (e.g., age, issues, what happened)

_____

_____

Have you made a suicide attempt? Yes (specify below) No

If YES, please describe when and the nature of the attempt:

Did you receive help? Yes (specify below) No

If YES, please describe when and the nature of the help you received:

_____

_____

_____

Have you seriously considered harming another person? Yes (specify below) No

If YES, describe when, who, and how:

_____

_____

_____

_____

Do you CURRENTLY have thoughts of harming another person? Yes (specify below) No

If YES, please describe:

_____

_____

Use of Substances: Please check any that apply

_____Alcohol ___daily ____weekly _____monthly _____rarely _____amount _____type

_____ Street Drugs ____daily _____weekly _____monthly ____rarely _____amount _____type

_____Prescription Medication _____daily ____weekly _____monthly ____rarely _____type

Estimate how many hours a day you spend online:

Facebook ____ Youtube _____ Gaming _____ School_____
Browsing ____ Texting _____ Work _____ Other_____

Do you currently view pornography? ____yes ____no
If so, how often? ___daily ____weekly ___monthly _____rarely
Do you consider this to be a problem?:

_____

_____

Current Situation:

Please describe below how you view your current situation (meaning the last two weeks):

_____

_____

_____

_____

_____

_____

_____

Please give a brief statement about what would have to happen for you to feel like this process was helpful to you. (Describe how your life would change)

_____

_____

_____

_____

_____

_____

_____

_____

Any other information that you feel is important to share that is not covered above:

_____
_____
_____
_____
_____
_____
_____