

**CONFIDENTIAL COUNSELING INFORMATION FORM**

**Village Presbyterian Church  
John A. Larsen, Ph.D.  
Licensed Psychologist**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Gender: M / F

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Is this the address where billing should be sent? Yes \_\_\_\_\_ No \_\_\_\_\_ Mobile Phone \_\_\_\_\_

If not, where? \_\_\_\_\_

Person to contact in emergency \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Relationship to you \_\_\_\_\_

List the persons with whom you are now living and their relationship to you (*Include ages of children*) \_\_\_\_\_

Your occupation \_\_\_\_\_ Your Education level \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_

Spouse's name \_\_\_\_\_ Birthdate \_\_\_\_\_

Spouse's occupation \_\_\_\_\_

Spouse's employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_

Referred by: \_\_\_\_\_

**PROBLEM INFORMATION**

Briefly describe the concerns that bring you to counseling \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Briefly describe the history and development of your concern from onset to present \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current symptoms** (*Please circle all that currently apply to you*):

Headaches, dizziness, fainting spells, anxiety, stomach trouble, loss of appetite, bowel disturbances, recent weight gain, recent weight loss, fatigue, sleep disturbances, nightmares, alcoholism, drugs, don't like weekends and vacations, loneliness, depressed, unable to have a good time, feelings of hopelessness, suicidal thoughts/feelings, shyness, can't make friends, unable to relax, over-ambitious, can't make decisions, excessive guilt, persistent fears, sexual concerns, obsessing, trouble concentrating, memory problems, recurrent troubling thoughts, racing thoughts, inferiority feelings, moodiness, irritable, angry outbursts, distractible, impulsiveness, grieving, other \_\_\_\_\_

\_\_\_\_\_

List current or past history of alcoholism or drug addiction for you or any family member \_\_\_\_\_

List current or past history of nervous or emotional disorder for you or any family member \_\_\_\_\_

**Current stressors** (*describe*)

Marriage and home \_\_\_\_\_

Children/parents \_\_\_\_\_

Work/school \_\_\_\_\_

Financial \_\_\_\_\_

Social \_\_\_\_\_

Spiritual \_\_\_\_\_

Sexual \_\_\_\_\_

Legal \_\_\_\_\_

Other \_\_\_\_\_

Major present stress \_\_\_\_\_

Rate how strongly you want to change your present problem on the scale below:

(do not want to change) 1 2 3 4 5 6 7 8 9 10 (desperately desire change)

In general, do you feel reasonably comfortable seeking counseling? Yes \_\_\_\_\_ No \_\_\_\_\_

Identify any specific concerns or anxieties you may have about counseling \_\_\_\_\_

\_\_\_\_\_

Previous counseling? \_\_\_\_\_ When? \_\_\_\_\_ By Whom? \_\_\_\_\_

How helpful was previous counseling? \_\_\_\_\_

\_\_\_\_\_

Please state your goals for counseling? (be as specific as possible) \_\_\_\_\_

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**FAMILY BACKGROUND**

Father's name \_\_\_\_\_ If deceased, date and cause \_\_\_\_\_

Age \_\_\_\_\_ Occupation \_\_\_\_\_ Education level \_\_\_\_\_ Health \_\_\_\_\_

Describe his personality, attitude and relationship to you, past and present \_\_\_\_\_

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Mother's name \_\_\_\_\_ If deceased, date and cause \_\_\_\_\_

Age \_\_\_\_\_ Occupation \_\_\_\_\_ Education level \_\_\_\_\_ Health \_\_\_\_\_

Describe her personality, attitude and relationship to you, past and present \_\_\_\_\_

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Parents' marital status \_\_\_\_\_ Briefly describe your parents' marriage \_\_\_\_\_

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How did they handle conflict in their relationship? \_\_\_\_\_

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If divorced, when did it occur and what was your reaction to it? \_\_\_\_\_

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If one or both parents remarried, give date(s) and your reaction \_\_\_\_\_

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Step-mother's name \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_

Step-father's name \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_

Describe their personality, attitude, and relationship to you--past and present \_\_\_\_\_

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If you were *not* brought up by your parents, who raised you? \_\_\_\_\_

Between what years? \_\_\_\_\_ Who took care of you as an infant? \_\_\_\_\_

How were you disciplined as a child and by whom? \_\_\_\_\_

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Brothers and sisters (list names, ages, marital status, occupations, and place of residence \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Give your impression of the home atmosphere in which you grew up, including how compatible you and everyone else were \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

As you were growing up, how was love expressed in your home? \_\_\_\_\_  
\_\_\_\_\_

How was anger expressed? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What were your parents' attitudes about sex and was there any discussion of or instruction about sexuality in the home?  
\_\_\_\_\_  
\_\_\_\_\_

Were you or your siblings ever abused? (check) *No* \_\_\_\_: *Yes* \_\_\_\_: Physically \_\_\_\_ Sexually \_\_\_\_ Emotionally \_\_\_\_  
Please describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**RELATIONSHIP HISTORY**

Single \_\_\_\_ Married \_\_\_\_ Separated \_\_\_\_ Divorced \_\_\_\_ Widowed \_\_\_\_ Cohabiting \_\_\_\_ Partnered \_\_\_\_

Length of engagement if married \_\_\_\_\_ Date of marriage \_\_\_\_\_

Describe the strengths of your relationship \_\_\_\_\_  
\_\_\_\_\_

Describe the areas of conflict in your relationship \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe your relationship with your in-laws \_\_\_\_\_  
\_\_\_\_\_

List names and ages of your children/step-children and indicate which (if any) are from a previous relationship \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dates of *previous* marriages/divorces \_\_\_\_\_

Status of relationship with ex-spouse if divorced \_\_\_\_\_

**FAITH JOURNEY**

Denominational preference \_\_\_\_\_ Member of Village Presbyterian Church: Yes \_\_\_ No \_\_\_  
Attend but not a member \_\_\_ Member of other church: Yes \_\_\_ No \_\_\_ Attend other church: Yes \_\_\_ No \_\_\_

Please describe the religious training you received growing up \_\_\_\_\_  
\_\_\_\_\_

Please comment on how you feel about your spiritual life at this time \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL**

Present health (*circle one*):      ***Excellent***                      ***Good***                      ***Fair***                      ***Poor***

What serious illnesses have you had and when?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Hospitalizations (*reason/diagnosis/dates*) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications currently taken--dosage/schedule--their purpose (*include non-prescription medications*).  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**NOTE: Counseling cannot proceed until you have read or received a copy of the HIPAA Notice and agreed to the terms of counseling spelled out in the Counseling Agreement.**

I have read or received a copy of the **Notice of Psychotherapist's Policies and Practices to Protect the Privacy of Client's Health Information (HIPAA)**. Please initial \_\_\_\_\_

I have read and accept the terms of the **Counseling Agreement**. Please initial \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature