CONFIDENTIAL COUNSELING INFORMATION FORM

Village Presbyterian Church
Dave Ehman, 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)*_____

_____

_____

_____

_____

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_____

_____

_____

Mother's name_____ If deceased, date and cause_____

Age_____ Occupation_____ Education level_____ Health_____

Describe her personality, attitude and relationship to you, past and present_____

_____

_____

Parents' marital status_____ Briefly describe your parents' marriage_____

_____

How did they handle conflict in their relationship? _____

_____

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

_____

If one or both parents remarried, give date(s) and your reaction_____

_____

_____

Step-mother's name_____ Age_____ Occupation_____

Step-father's name_____ Age_____ Occupation_____

Describe their personality, attitude, and relationship to you--past and present_____

_____

_____

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? _____

_____

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