PERSONAL INFORMATION FORM

Please answer the following questions as fully as possible.
Information you provide will assist your counselor in providing the best care

Name: ____ Date: ___________________________________

Address: ____ City: ___________________________________

Home Phone: __________________ Cell: _________________ Birth Date: ______________________________

What # would you prefer to be contacted? Home_______ Cell________

E-mail Address: ____

Please describe the issue(s) that have brought you to Ascensions Counseling Center: _____________________________

____

____

In what areas has this issue(s) affected your life?

Family: ____ Work: _____ Spiritually: _____ Socially: _______ Recreationally: _______ Physical Health: ________

Please explain in detail the above areas of difficulty: ____

____

____

____

How long has this issue been affecting your life? ____

____

____

____

In your view, how serious is this problem?

❏ mildly ❏ moderately ❏ very ❏ extremely ❏ totally

What have you tried to do to solve this problem? ____

____

What has been successful? ____

Have you had counseling/therapy in the past? ☐ Yes ☐ No

If so, where? ______________________________ When? ____________________

What was helpful about the counseling? ______________________________________

What was not helpful about the counseling? ____________________________________

MARITAL STATUS:

☐ Single ☐ Married How long?____

☐ Previously married – How many times? ______________________________________

☐ Committed Relationship – How long? ______________________________________

☐ Living with someone – How long? ____

☐ Separated – How long? ____

☐ Widowed – How long? ____

FAMILY HISTORY:

Family members or persons currently living with you:

Name	Relationship	Age	Current School Grade or Occupation

Do you currently live in: ☐ House ☐ Room ☐ Apartment ☐ Other: ____________________

Please list any of your children currently not living with you:

Name	Age	Where Living and with Whom

City and State of major childhood residence: ______________________________________

Parents: ☐ Married ☐ Divorced ☐ Separated ☐ Living Together

FATHER: Name:_____________ Age: _____ or Age at Death: _____ Cause of Death: ______________________________
How old were you? _______
Ethnic Background: ____ Religion: ________________________________
Citizenship: ____ Education: ______________________________
Occupation: ____ Health: __________________________________

MOTHER: Name:____________ Age: _____ or Age at Death: _____ Cause of Death: ______________________________
How old were you? _______
Ethnic Background: ____ Religion: ________________________________
Citizenship: ____ Education: ______________________________
Occupation: ____ Health: __________________________________

Brothers: Name:____________ Age :_________or Age at Death:______ Cause of Death:_____________________________
Name:____________ Age :_________or Age at Death:______ Cause of Death:_____________________________
Name:____________ Age :_________or Age at Death:______ Cause of Death:_____________________________

Sisters: Name:____________ Age :_________or Age at Death:______ Cause of Death:_____________________________
Name:____________ Age :_________or Age at Death:______ Cause of Death:_____________________________
Name:____________ Age :_________or Age at Death:______ Cause of Death:_____________________________

What is your birth order (oldest, youngest, middle, only child)? ____

How would you describe your relationship with your parents and siblings? Is there anyone that you are particularly distant from or close with? Have problems with? ____

____

____

If you were not brought up by your parents, who raised you? Between what years? _________________________________

____

Were you adopted? ❑ Yes ❑ No *If yes*, from what age did you know? _______________________

Does anyone in your family suffer from a mental or emotional disorder (depression, anxiety, alcoholism, schizophrenia, etc.)? ❑ Yes ❑ No Please explain ____

____

Has any one of your relatives ever attempted or committed suicide? ❑ Yes ❑ No

Did any of the following apply to your childhood or adolescence?

____ Happy childhood
____ Unhappy childhood
____ Family problems
____ Alcohol abuse
____ Drug abuse
____ Neglected
____ Severely Punished
____ Emotional problems
____ Behavioral problems
____ School problems
____ Legal troubles
____ Medical problems
____ Financial problems
____ Strict religious upbringing
____ Physical abuse
____ Sexual abuse
____ Emotional abuse
____ Traumas
____ Severely bullied/or teased
____ Very few friends

EDUCATION:

What is the last grade of school you completed or highest degree? ____

Are you in school now? ❑ Yes ❑ No If yes, where? ___________________________ Major? _____________________

Other training: ______________________ Strengths: _______________________ Weaknesses: _____________________

Childhood Educational and Developmental History:

– please answer the following questions based on your childhood:

Birth defects or handicaps? ❑ Yes ❑ No Speech problems? ❑ Yes ❑ No

History of learning disabilities? ❑ Yes ❑ No What subject(s)? ____

Special education? ❑ Yes ❑ No What grade(s)? __________ Tutoring? ___________________

Explain____

Repeated any grades? ❑ Yes ❑ No Grade(s)? ____

Behavioral problems? ❑ Yes ❑ No If yes: Where? ❑ Home ❑ School

Nature of problems: ____

Problems with peers? ❑ Yes ❑ No Nature of problems: ____

WORK HISTORY:

Current Employment Status:

	You	**Spouse**	**Military Data**
Employed full-time	_____	_____	**You:**
Employed part-time	_____	_____	Active duty? ______________________________
Laid-off	_____	_____	Branch? __________________________________
Unemployed	_____	_____	Discharge? _______________________________
Disabled	_____	_____	
			Military Data
Retired	_____	_____	**Spouse:**

Stay-home mom or dad _____ _____ Active duty? ____________________________

Student _____ _____ Branch? _______________________________

Other _______________ _____ _____ Discharge? _____________________________

What type of work do you do? ____________________________ Spouse? ________________________________

PHYSICAL AND MENTAL HEALTH:

How would you rate your current physical health?

Very poor 1 2 3 4 5 6 7 8 9 10 Very good

List current health problems for which you are receiving treatment: ____

____

Primary Care Physician (name, address, phone number): ____

____

Date of last medical exam: _____________________________________

List any medical problems you are currently experiencing: ____

____

List any physical disabilities you have: ____

____

Name of medication	Dosage	Frequency	Reason
______________________________	___________	___________	_______________________________________
______________________________	___________	___________	_______________________________________
______________________________	___________	___________	_______________________________________
______________________________	___________	___________	_______________________________________

Do you exercise? _____ Yes _____ No *If yes,* what type? ____

Do you eat balanced meals? _____ Yes _____ No *If no,* explain: ____

How much caffeine do you consume per day (in coffee, soft drinks, tea)? ______________________________________

Do you smoke? _____ Yes _____ No *If yes,* for how long? _______________ How much? _____________________

Have you ever tried to quit? _____ Yes _____ No *If yes,* what method(s) did you try? __________________________

OB/GYN (FEMALE ONLY)

Last GYN Exam: ____

Date of last menstrual period: ___________________ Duration and Frequency: _________________________________
Number of Pregnancies: _______________________ Due date if now pregnant: _______________________________
Number of Miscarriages: _______________________ Number of Stillbirths: ___________________________________
Number of Abortions: __________________________ Number of Live Births: __________________________________
Are you breastfeeding now? ❑ No ❑ Yes

What is your current use of alcohol? ____

____

Have you had problems with alcohol/drug use in the past? ❑ Yes ❑ No

If yes, please explain: ____

What is your current use of other drugs? ____

Have you been arrested for alcohol/drug related offenses? ❑ Yes ❑ No
Have you had treatment for problems with alcohol abuse/dependency? ❑ Yes ❑ No When?___________________
Do you have a history of drug use? ❑ Yes ❑ No
Have you had treatment for drug abuse/dependency? ❑ Yes ❑ No When?__________________________________
Have you ever lost a job/relationship due to the use of alcohol/drugs? ❑ Yes ❑ No

How do you occupy your free time (present interests, hobbies, activities, projects)? _____________________________

____

Whom/What do you consider the strongest supports in your life (God, family, friends, group memberships/involvement, hobbies, interests)? ____

Do you make friends easily? _______ Do you currently have any committed friendships? _______

Have you ever had thoughts of suicide (killing yourself)? ❑ Yes ❑ No *If yes,* when? ______________________

Have you ever taken any action toward ending your life)? ❑ Yes ❑ No *If yes,* please explain: ______________

____

Have you ever had thoughts or plans of homicide (killing someone else))? ❑ Yes ❑ No

If yes, please explain: ____

EMOTIONAL SYMPTOMS CHECKLIST
ADULT (OVER AGE 18)

CURRENT SYMPTOM CHECKLIST – Please rank each symptom below on a scale of 0 – 5

0 = Not a problem 1 = Minimal 2 = Mild 3 = Moderate 4 = Serious 5 = Severe

_______ I have plans to hurt myself
_______ Alcohol use
_______ I engage in reckless/unsafe behaviors
_______ I am pregnant (____ weeks)
_______ Loss of baby
_______ I have a chronic medical condition
_______ I am depressed/sad
_______ I have problems with eating
_______ I am confused in my thinking
_______ I can't concentrate
_______ I have physical complaints
_______ I am socially isolated/withdrawn
_______ I feel completely alone in the world
_______ I really do not want to be here
_______ I wish I did not need help
_______ I have no interest in my usual activities
_______ I sleep between 12-18 hours per day
_______ I have interrupted sleep
_______ I am unable to relax
_______ I experience shortness of breath
_______ I have thoughts that someone wants to hurt me
_______ I have overwhelming fears
_______ I have a feeling of hopelessness
_______ I do not recall periods of time in a day
_______ I am compelled to repeat activities

_______ I have plans to hurt someone else
_______ Drug(s) use
_______ I may be pregnant
_______ My pregnancy is a problem
_______ I am experiencing chronic pain
_______ I am grieving/coping with loss
_______ I experience frequent mood changes
_______ I hear voices
_______ I procrastinate
_______ I have sexual issues
_______ I experience difficulty in my relationships
_______ I feel empty inside
_______ I don't know who I am as a person
_______ Therapy doesn't work
_______ I am angry and/or have outbursts of anger
_______ I act in ways that hurt me physically
_______ I sleep less than 6 hours per day
_______ I feel tired all the time
_______ I have racing thoughts
_______ I have recurrent nightmares
_______ Change in appetite
_______ Loss of sexual desire
_______ I have periods of uncontrollable crying
_______ Unable to recall memories after age 5
_______ I have recurrent thoughts throughout the day

PSYCHOLOGICAL AND ENVIRONMENTAL CHECKLIST

CURRENT SYMPTOM CHECKLIST – Please rank each symptom below on a scale of 0 – 5

0 = Not a problem 1 = Minimal 2 = Mild 3 = Moderate 4 = Serious 5 = Severe

Please rate each of the following problem areas that have been present during the past year or those occurring prior to one year if they clearly contribute to the reasons for seeking treatment. Please write in the specific problem:

_______ Problems with primary support group: Death of a family member, separation, divorce, removal from home, sexual or physical abuse, discord in the family with parents, siblings, or other like events.

_______ Problems related to the social environment: death or loss of a friend, living alone, discrimination, adjustment to life-cycle transitions, such as leaving home or retirement.

_______ Educational problems: unable to read, academic problems, discord with teachers or classmates.

_______ Occupational problems: Unemployment, threat of job loss, stressful work schedule, discord with boss or coworkers.

_______ Housing problems: homeless, unsafe neighborhood, discord with neighbors or landlord.

_______ Economic problems: not enough money to pay for bills, food, and rent.

_______ Problems with access to health care services: inadequate health care, transportation to health care facilities unavailable, inadequate health insurance.

_______ Problems related to interaction with the legal system/crime: arrest, incarceration, litigation, victim of a crime.

_______ Other psychological and environmental problems: exposure to disasters, discord with non-family caregivers such as counselor, social worker or physician, unavailability of social service agencies.

1. When did you begin to experience the above-mentioned symptoms that you have rated 3 or higher? _____________

____

2. Do symptoms that you have rated 3 or higher worsen when certain events take place? _________________________

____

3. How do symptoms that you have rated 3 or higher affect your day-to-day life? (i.e. your ability to go to school or work, how you relate to others, how you care for yourself and/or your child(ren), how social or anti-social you are in general, etc.) ____

____

____

4. Was there something specific that happened to you or someone else which may have contributed to and/or caused the symptoms you have rated 3 or higher? ____

5. What have you tried that has improved your symptoms you have rated 3 or higher? ___________________________

____

6. What do you hope to change and/or learn as a result of being seen for treatment? ____________________________

____

Client signature: ____ Date: _____ / _____ / __________

Therapist signature/certification: _____________________________________ Date: _____/ _____ / __________