

White River Christian Church
Counseling Information

**Your right to privacy protects this form and its content.
It cannot be released to anyone except by your written permission.**

PERSONAL Information:

Name _____ Birth Date _____
Address _____ Home Phone _____
Cell Phone _____ Business Phone _____ Pager _____
Referred by: _____
Employer _____ Position _____
Education (last yr. completed or degree) _____
Current Marital Status: Never Married ___ Engaged ___ Married ___ Separated ___ Divorced ___ Widowed ___
In case of emergency contact _____

Marriage and Family Information:

Spouse _____ Birth Date _____
Occupation _____ How Long _____
Education (last yr. Completed or degree) _____
Date of Marriage _____ Length of dating relationship _____ Give a brief statement of circumstances of meeting and dating _____

List your children:

Name _____ Male/Female Age: _____ Living _____ Deceased _____
Name _____ Male/Female Age: _____ Living _____ Deceased _____
Name _____ Male/Female Age: _____ Living _____ Deceased _____
Name _____ Male/Female Age: _____ Living _____ Deceased _____

If you or your spouse have been married previously or had children from previous relationships, please fill out the following information:

Husband -

Former Spouse's first name _____ Death ____ Divorce ____

Married from Month/Yr. _____ To Month/Yr. _____

Children: _____ Male/Female Age: ____ Living with: _____ Deceased _____

_____ Male/Female Age: ____ Living with: _____ Deceased _____

_____ Male/Female Age: ____ Living with: _____ Deceased _____

Other important relationships of husband: _____

Wife -

Former Spouse's first name _____ Death ____ Divorce ____

Married from Month/Yr. _____ To Month/Yr. _____

Children: _____ Male/Female Age: ____ Living with: _____ Deceased _____

_____ Male/Female Age: ____ Living with: _____ Deceased _____

_____ Male/Female Age: ____ Living with: _____ Deceased _____

Other important relationships of wife: _____

Health:

Describe your health _____

Do you have any chronic conditions _____ What _____

Current medications and dosage _____

Do you drink alcoholic beverages _____ If so, how frequently and how much _____

Do you currently or have you in the past used drugs other than for medical purposes? _____

Have you ever had a **severe** emotional upset _____ If yes, please explain _____

Have you ever seen a psychiatrist or counselor _____ If yes, please explain _____

Spouse's Health (if applicable):

Describe his/her health _____

Does he/she have any chronic conditions _____ What _____

Current medications and dosage _____

Does he/she drink alcoholic beverages _____ If so, how frequently and how much _____

Does he/she currently or have you in the past used drugs other than for medical purposes? _____

Has he/she ever had a **severe** emotional upset _____ If yes, please explain _____

Has he/she ever seen a psychiatrist or counselor _____ If yes, please explain _____

Spiritual Life:

Do you believe in God Yes Yes but I have doubts No

Would you say you are a Christian Yes In the Process No

Do you pray regularly _____ Do you read the Bible regularly _____

Church you attend _____ Member Yes No

Number of Sunday's you attend Church each month Every Sunday Once Twice

Is there anything that your counselor should know about your spiritual life _____

Emotional Health:

CIRCLE any of the following words which best describe you now: Active Ambitious

Moody Self-confident Persistent Nervous Hardworking Impatient

Impulsive Kindly Often-blue Excitable Imaginative Calm Serious

Easy-going Shy Good-natured Introvert Extrovert Likeable Leader

Quiet Hard-boiled Submissive Spiritual Self-conscious Lonely Sensitive

Fearful Anxious Regimented

Problem Check List

<input type="checkbox"/> Anger	<input type="checkbox"/> Envy	<input type="checkbox"/> Appetite	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Fear	<input type="checkbox"/> Memory	<input type="checkbox"/> Apathy	<input type="checkbox"/> Gluttony
<input type="checkbox"/> Moodiness	<input type="checkbox"/> Bitterness	<input type="checkbox"/> Guilt	<input type="checkbox"/> Rebellion
<input type="checkbox"/> Health	<input type="checkbox"/> Sex	<input type="checkbox"/> Children	<input type="checkbox"/> Change in lifestyle
<input type="checkbox"/> A Vice	<input type="checkbox"/> Depression	<input type="checkbox"/> Impotence	<input type="checkbox"/> Abuse
<input type="checkbox"/> Deception	<input type="checkbox"/> In-laws	<input type="checkbox"/> Grief	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Blended Family	<input type="checkbox"/> Chronic Illness		

Briefly answer the following questions:

What brings you to counseling?

What have you already tried to do about this?

What are your expectations from counseling?

Is there any information that is very important for the counselor to know?