Confidential Questionnaire

Personal Information

Name ______________________________

Address ______________________________

City, State, Zip ______________________________

Home Phone ______________________________

Ok to leave a message? Y or N

Work or Cell Phone ______________________________

Ok to leave a message? Y or N

Date of Birth ______________________________

Social Security # ______________________________

Marital Status ______________________________

Occupation ______________________________

Referred by ______________________________

Emergency Contact ______________________________

Relationship and Phone ______________________________

Spouse Information

Spouse ______________________________

Date of Birth ______________________________

Social Security # ______________________________

Years Married ______________________________

Occupation ______________________________

Children

Children	Name	Age

Health Information (If married, please identify answers with initials)

Name of physician ______________________________ Phone ______________________________

Current Medications	Dosage	Date Prescribed

Overall Health Very good ________ Average ________ Declining ________

Recent Health Changes (condition, sleep, weight, etc.) ______________________________

Significant Losses Suffered (please explain) ______________________________

Other Information

Previous Counseling	Date	Name of Therapist	Reason for Counseling

Briefly describe your belief in God, and if or how you see your faith being a part of the change process.

What has brought you here today? ______________________________

Please circle any areas of concern you may wish to discuss during the counseling process:

stress	grief & loss	occupational concerns	sexual issues	finances
anger	faith	communication	parents/in-law	appearance
anxiety	depression	substance abuse/overuse	childhood hurts	past abuse
parenting	marital issues	relational conflicts	suicidal thoughts	abortion