

Name _____

Presbyterian Counseling Center

Date of Birth _____

Individual Therapy Initial Information Form

Date _____

Current Situation

What concern brings you to therapy? How long has this been a problem? What have you been doing about it? What do you hope to get out of therapy now?

Yourself

What strengths and assets do you have?

- | | |
|---|---|
| <input type="checkbox"/> Able to express feelings appropriately | <input type="checkbox"/> Good physical health |
| <input type="checkbox"/> Accuracy of perception | <input type="checkbox"/> Insight into problems |
| <input type="checkbox"/> Awareness of assets & limitations | <input type="checkbox"/> Leisure interests |
| <input type="checkbox"/> Capable of independent living | <input type="checkbox"/> Motivated for treatment |
| <input type="checkbox"/> Capacity for logical thinking | <input type="checkbox"/> Belief/Religion/Spiritual Practice |
| <input type="checkbox"/> Community support | <input type="checkbox"/> Self-esteem |
| <input type="checkbox"/> Employment stability | <input type="checkbox"/> Support of family & friends |
| <input type="checkbox"/> Financially stable | <input type="checkbox"/> Supportive groups |
| <input type="checkbox"/> Flexibility of adaptation | <input type="checkbox"/> Work skills |
| <input type="checkbox"/> Frustration tolerance | <input type="checkbox"/> Other _____ |

Mental Health History

Have you ever been to a counselor before? No Yes How many? ____ How many sessions? ____
Any psychiatric hospitalizations? No Yes How many times? ____

Health History

In general, my health is Excellent Good Fair Poor

When was your last physical examination? _____

Do you use tobacco? No Yes ____ Packs/day Other _____

The nutritional value and balance of your diet is: Excellent Good Fair Poor

How often do you exercise? Daily 2-4 times per week Occasionally Never

Has your weight changed in recent months? No Yes. How many pounds? _____ ↑ ↓

How much sleep do you get? _____ hours of what quality? Good Fair Poor

Any trouble with sexual functioning? No Yes _____

Any allergies: Seasonal Food Medicine _____

Names of medications you take How much? How often? Do you take it consistently?

_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name _____

Alcohol and Drug

Have you ever had concerns about your use of alcohol, medicines or drugs? Yes No
Has anyone else ever expressed concern about your use of alcohol, medicine or drugs? Yes No
Have you or anyone else had concerns about your use of sex, food or gambling? Yes No
Check any that you have had because of alcohol, medicine, drugs, sex, food or gambling.
 Financial problems Relationship problems Work problems
 Increased tolerance Physical problems Emotional problems
 Blackouts Withdrawal symptoms Cravings

Education

Completed: ___ Grade GED High School Some college/VoTech College More
Describe your school experience: _____

Employment

Full time Part time Student Volunteer Homemaker
 Unemployed since _____ Disabled since _____ Retired since _____
How long at current job? _____ Yrs Mo Type of work: _____
How long at previous job? _____ Yrs Mo Type of work: _____
Any problems at work? No Yes _____
Were you in the military? No Yes. Combat duty? Yes No. Which service? _____

Relationships

Are you currently in a relationship? Married Committed Dating
Sexual satisfaction: Very satisfied So-so Unsatisfied No sexual relationship right now
Previous marriages? No Yes _____
Your children and their ages: _____

Who lives with you?	Name	Age	Relationship

Any concerns about them? No Yes _____
Has any partner been abusive to you? No Yes _____

Family History

Your Father: Living, age _____. Died at age _____. How old were you at his death? _____
Your Mother: Living, age _____. Died at age _____. How old were you at her death? _____
Their marriage: Very happy Happy Ok Unhappy Very unhappy
Were your parents divorced? No Yes How old were you? _____
How often were you spanked as a child? Never A few times Often Whipped Beaten
How many brothers? _____ How many sisters? _____ Where are you in birth order? _____
How were your relationships with your siblings? Loving Squabbles Fights Destructive
Any members of your family ever had a problem with any of these things? Who was it?

