Redeemed
Christian Counseling & Education

Counseling Information Survey

Instructions: Please complete this as accurately as possible, including any information that you feel could benefit the counseling process. All information contained in this survey is confidential except as prohibited by state/federal law regarding major criminal offenses and child, elderly, and disabled persons abuse.

Personal Information

Name_____ Birth day/year _____Date_____

Street Address_____

City_____State_____ZIP_____

Email_____ Phone #_____

Employer_____

Current profession_____

Education Highest grade or degree completed_____

Have you been in the military? __yes __no If yes, were you in combat? __yes __no

Marital Status: __ single __ married (date of marriage_____)
__divorced __widowed __remarried __ cohabitating

In your current marriage:
Does your spouse know that you have come here for counseling?_____

Would your spouse come for counseling? _____

Have you separated or filed for divorce? _____

Please list children:

Name	Gender	Age	Living in the home
1) _____	_____	_____	_____
2) _____	_____	_____	_____
3) _____	_____	_____	_____
4) _____	_____	_____	_____
5) _____	_____	_____	_____

Emergency Contact Information

In case of an emergency contact:

Name_____Relationship_____

Address_____

Phone (cell) _____ (work) _____

Reason for seeking counseling: What specific issues(s) in your life are you hoping will be addressed through the counseling process?

_____

Circle the words to describe **why you need counseling**:

Grief	Depression	Anxiety	Nervousness	Fear
Self-doubt	Guilt	Suicidal thoughts	Loneliness	Marriage problems
Sexual concerns	Impotency	Homosexuality	Adultery	Compulsive lust
Loss of hope	Loss of meaning	Loss of self-respect	Loss of love	Bitterness
Anger with God	Religious doubts/fear			
Relationship:	with parents	with children	with spouse	with others
Loss of faith:	in God	in self	in others	

Have you been in counseling or therapy before? ___Yes ___No If yes, was it helpful? _____
List dates, counselors, problems _____
_____

Physical Health
Rate your health: __ poor __ fair __ average __good
Date of last medical exam: _____ Do you drink caffeine? ___ How much a day? _____

Please list your allergies: _____

Please indicate your pregnancy history by circling all that apply:
abortion adoption miscarriage still birth

List all major illnesses/injuries/ disabilities:
_____
_____

Has your weight changed more than 10 lb. in the past months? __ Yes __ No
__ Gained __ Lost How much? ___

Family Background

Parents:
Are your parents living? mother __ yes __no father __yes ___no
Are they living together? __yes __no
Are they divorced? __yes __no If yes, how old were you when they divorced? _____
Are they remarried? mother __ yes __no father __yes ___no

Was your relationship with your mother: ___close ___ distant ___ conflicted
Was your relationship with your father: ___close ___ distant ___ conflicted

Please list siblings:

Name (optional)	Gender	Age	Living in the home
1) _____	_____	_____	_____
2) _____	_____	_____	_____
3) _____	_____	_____	_____
4) _____	_____	_____	_____
5) _____	_____	_____	_____

Where do you fall in the birth order? _____
How was your relationship with your siblings growing up? ___close ___ distant ___ conflicted
Was yours a basically happy or unhappy home during childhood? _____

Were there any instances of abuse in your family?

			By whom?	Abuse directed toward?
Verbal	____ Yes	____ No	_____	_____
Emotional	____ Yes	____ No	_____	_____
Physical	____ Yes	____ No	_____	_____
Sexual	____ Yes	____ No	_____	_____
Alcohol	____ Yes	____ No	_____	_____
Drugs	____ Yes	____ No	_____	_____
Compulsive habits	____ Yes	____ No	_____	_____

Other problems not mentioned _____

Spiritual History

Note: The counseling provided will be conducted from a faith based perspective. While the counselee does not have to be of the Christian faith they understand that issues of faith will be an important component of the counseling process.

What is your religious or church background? _____

Are you currently active in your church? _____

How would you describe your relationship with God? _____
_____
_____

Mood Inventory

Do you have any of the following symptoms:

	Yes	No
1. Change in eating habits (poor appetite/overeat)?	_____	_____
2. Change in sleeping patterns (insomnia/oversleeping)?	_____	_____
3. Have a lack of motivation/energy for ordinary tasks?	_____	_____
4. Have feelings of hopelessness?	_____	_____
5. Have ever thought of harming yourself or someone else?	_____	_____
6. Have poor concentration and difficulty making decisions?	_____	_____
7. Have you ever been diagnosed with:		
Depression	_____	_____
Schizophrenia	_____	_____
obsessive compulsive disorder	_____	_____
attention deficit disorder	_____	_____
anxiety disorder	_____	_____
Bipolar	_____	_____
other (please describe) _____	_____	_____
8. Have you personally ever received psychiatric treatment?	_____	_____
9. Has any member of your family ever received psychiatric treatment?	_____	_____
If yes, who and what was the diagnosis: _____		
10. Feel mentally confused?	_____	_____
11. Self-medicate (through alcohol, sex, food, work, entertainment, etc.)?	_____	_____
12. Have short term memory loss?	_____	_____
13. Have panic attacks?	_____	_____
14. Hear voices that other's do not?	_____	_____
15. Are you now undergoing psychiatric treatment?	_____	_____
16. Are you currently on medications?	_____	_____
If so, which ones? _____		

Addiction Inventory

Have you ever been addicted to any of the following:

	Currently		In the Past	
Alcohol	Yes ____	No _____	Yes ____	No _____
Substances	Yes ____	No _____	Yes ____	No _____
Tobacco	Yes ____	No _____	Yes ____	No _____
Food	Yes ____	No _____	Yes ____	No _____
Gambling	Yes ____	No _____	Yes ____	No _____
Pornography	Yes ____	No _____	Yes ____	No _____
Sex	Yes ____	No _____	Yes ____	No _____

Other (please list) _____

Has anyone in your family been addicted to any of the above? _____

If yes, which ones and by whom? _____

_____

Personal Inventory
Describe yourself in as many one or two word phrases as possible:

1) _____ 6) _____
2) _____ 7) _____
3) _____ 8) _____
4) _____ 9) _____
5) _____ 10) _____

Additional Information
Please describe any additional information that you feel is important to the counseling process.
_____
_____
_____
_____

Miscellaneous Information
If referred here, by whom? _____

Do we have your permission to tell them thank you? ____ Yes ____ No

Do you prefer, ☐ Male ☐ Female ☐ No Preference, Counselor?

Name (if specific request)_____

Payment Information
Payment for counseling services is due upon receipt of services. I will be charged full fee to my credit card on file for appointments cancelled with less than 24 hour notice.

_____ _____
Signature Printed Name

_____
Date