

**ROBERT P. GERHOLZ CENTER FOR CHRISTIAN COUNSELING
INFORMATION FORM**

DATE: _____

Name: _____ Sex: *M or F* Date of birth: _____ Age: _____

Address: _____ City: _____ Zip code: _____

Telephone: Home: _____ Work: _____ Cell: _____

Occupation: _____ Okay to contact at work? *YES NO*

Emergency contact name: _____ Relationship: _____

Primary number: _____ Second number: _____

Name of Spouse/Partner _____ Date of Birth: _____ Age: _____
(Parent, If Seeking Help For Child if Address is Different)

Telephone: Home: _____ Work: _____ Cell: _____

Occupation: _____ Okay to contact at work? *YES NO*

Address: _____ City: _____ Zip code: _____

LIST ALL FAMILY MEMBERS LIVING IN OR OUT OF THE HOME:

Name	Age	Sex	Occupation/School	Relationship /Quality of Rel.	Living at Home
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

I/ HAVE COME TO THE GERHOLZ CENTER FOR: (CHECK ALL THAT APPLY)

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> adult child of alcoholic | <input type="checkbox"/> aging parent issues | <input type="checkbox"/> anger issues | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> child custody issues | <input type="checkbox"/> depression | <input type="checkbox"/> divorce recovery | <input type="checkbox"/> eating disorder |
| <input type="checkbox"/> family of origin issues | <input type="checkbox"/> financial issues | <input type="checkbox"/> legal problems | <input type="checkbox"/> loss from death |
| <input type="checkbox"/> low self esteem | <input type="checkbox"/> marital issues | <input type="checkbox"/> marital reconciliation | <input type="checkbox"/> parent-child issues |
| <input type="checkbox"/> physical abuse | <input type="checkbox"/> pregnancy issues | <input type="checkbox"/> school difficulties | <input type="checkbox"/> separation |
| <input type="checkbox"/> sexual abuse | <input type="checkbox"/> sexual dysfunction | <input type="checkbox"/> spiritual concerns | <input type="checkbox"/> suicidal ideation |
| <input type="checkbox"/> substance abuse | <input type="checkbox"/> vocational direction | <input type="checkbox"/> other (please specify) | |

PERSONAL INFORMATION:

MOTHER

Name: _____
Occupation: _____
Age: _____ Religion: _____
DISTANCE (in time or miles) from your home to hers: _____

FATHER

Name: _____
Occupation: _____
Age: _____ Religion: _____
DISTANCE (in time or miles) from your home to his: _____

Describe Your Relationship: _____

Describe Your Relationship: _____

NAME: _____

Are your parents still together? *YES / NO*
If deceased, year of Mother's death _____

Date of Separation/Divorce (if any) _____
Year of Father's death _____

SIBLING RELATIONSHIPS—Including Step-siblings (Use back if Necessary)

Name	Age	Occupation/School	Describe your relationship

Are you married or in a long-term relationship now? *YES / NO*
If yes: Date of Marriage/Lived together _____ Date of Separation/Divorce _____

Have you been married or in a long-term relationship before? *YES / NO*
If yes: Date of Marriage/Lived together _____ Date of Separation/Divorce _____
Date of Marriage/Lived together _____ Date of Separation/Divorce _____

Has your partner been married before? *YES / NO*
If yes: Date of Marriage/Lived together _____ Date of Separation/Divorce _____
Date of Marriage/Lived together _____ Date of Separation/Divorce _____

Rate your relationship with Spouse or Significant Other (Circle One)
VERY BAD BAD OKAY GOOD EXCELLENT

Please list any Significant Deaths or Losses (Including Dates) _____

EDUCATION: (Circle the highest number of years that you have completed)

1 2 3 4 5 6 7 8 9 10 11 12 (*HIGH SCHOOL DIPLOMA OR GED*)
Technical Training Associate's Degree BA/BS MA OTHER

EMPLOYMENT:

Do you have a job? *YES / NO* If yes, how long at current job? _____

How do you feel about your job? *LOVE IT IT'S OKAY HATE IT*

Military Service: *YES / NO* ___Army ___Air Force ___Marines ___Navy ___National Guard

LEGAL:

Have you ever been convicted of a crime? *YES / NO* *If yes, please explain:*

FRIENDSHIPS:

How many close friends do you have? ___1 ___2 or More

How satisfied are you with your friendships? ___Very Satisfied ___Somewhat Satisfied ___Not Satisfied

NAME: _____

CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU AT PRESENT:

- | | | |
|---|--|---|
| <input type="checkbox"/> Always tired | <input type="checkbox"/> Depressed | <input type="checkbox"/> Feel like hurting someone |
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Feeling lonely | <input type="checkbox"/> Trouble sleeping |
| <input type="checkbox"/> Not enjoying things | <input type="checkbox"/> Feel like smashing things | <input type="checkbox"/> Loss of weight |
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> weight gain | <input type="checkbox"/> Feeling inferior |
| <input type="checkbox"/> Shy with people | <input type="checkbox"/> Lack of energy | <input type="checkbox"/> Loss of sexual interest |
| <input type="checkbox"/> Loss of meaning to life | <input type="checkbox"/> Fast heartbeat | <input type="checkbox"/> No one understands me |
| <input type="checkbox"/> Frequent sweating | <input type="checkbox"/> Worried about health | <input type="checkbox"/> Feeling of guilt |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Can't concentrate | <input type="checkbox"/> Unable to pray |
| <input type="checkbox"/> Shaky hands | <input type="checkbox"/> "Can't get along" | <input type="checkbox"/> Feeling angry |
| <input type="checkbox"/> Feeling tense | <input type="checkbox"/> Unable to experience forgiveness or peace | |
| <input type="checkbox"/> Stomach trouble | <input type="checkbox"/> Feeling tense | <input type="checkbox"/> Don't like being alone |
| <input type="checkbox"/> Unresolved grief | <input type="checkbox"/> Cold feet & hands | <input type="checkbox"/> Always worried |
| <input type="checkbox"/> Feeling panicky | <input type="checkbox"/> Confused about personal religious practices | |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Feeling panicky |
| <input type="checkbox"/> Muscles twitching or jumping | <input type="checkbox"/> Overly ambitious | <input type="checkbox"/> Can't make decisions |
| <input type="checkbox"/> Financial problems | <input type="checkbox"/> Nausea or vomiting | <input type="checkbox"/> Can't make friends |
| <input type="checkbox"/> Marital problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Unable to relax |
| <input type="checkbox"/> Difficulties at work | <input type="checkbox"/> Poor physical health | <input type="checkbox"/> Fearful |
| <input type="checkbox"/> Can't hold a job | <input type="checkbox"/> Overly sensitive | <input type="checkbox"/> Excessive use of medications |
| <input type="checkbox"/> Full of energy | <input type="checkbox"/> Sexual problems | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Easily excited | <input type="checkbox"/> Excessive use of drugs | <input type="checkbox"/> Crying spells |
| <input type="checkbox"/> Quick tempered | <input type="checkbox"/> Unable to have fun | <input type="checkbox"/> Impatient with people |
| <input type="checkbox"/> Problems with children | <input type="checkbox"/> Easily angered | <input type="checkbox"/> Feeling easily hurt |
| <input type="checkbox"/> Very restless | <input type="checkbox"/> Fighting and quarreling | <input type="checkbox"/> Lacking in confidence |
| <input type="checkbox"/> Feeling grouchy | <input type="checkbox"/> Difficulties at school | <input type="checkbox"/> Can't handle money |

MEDICAL INFORMATION

Personal Physician _____ Address _____

Date last seen _____ Date of last physical exam _____

Any current medical problems? _____

Medication you are currently taking (Name and dosage): _____

Do you view your use of prescription drugs a problem? *Yes or No*

Please list hospitalizations (Medical, Detox/Rehab, and Psychiatric) and surgeries: _____

Do you use alcohol? *NEVER* *RARELY* *OCCASIONALLY* *OFTEN* *DAILY*

Do you use non-prescription drugs? *NEVER* *RARELY* *OCCASIONALLY* *OFTEN* *DAILY*

Are (were) any of the following alcohol or drugs users/abusers?

spouse/partner *parent* *child* *sibling* *grandparent*

aunt *uncle* *friend* *other relative* *other*

NAME: _____

RELIGIOUS INFORMATION

What is your religion?

Protestant *Catholic* *Jewish* *Muslim* *Other* *None*

Do you attend church?

Regularly *Frequently* *Sometimes* *Seldom* *Never*

Do you wish your pastor to be informed that you are in counseling? *Yes / No*

In what religious tradition did you grow up? _____ Is religion/faith important to you? *Yes / No*

Have you experienced God at work in your life? *Yes / No*

If yes, would you like to discuss this with your counselor? *Yes / No*

What words would you use to describe your relationship with God? (circle all that apply)

awesome *close* *distant* *good* *angry* *confused* *joyful*
 forgiven *being punished* *strained* *other? (please describe)*

What kind of help do you want to receive here? _____

I/we have already tried: (Check all that apply)

individual counseling *couple counseling* *group counseling* *hospitalization*
 partial hospitalization *medication* *prayer* *pastoral counseling*
 support group *other (please specify)*

Who else is affected by the problem: (Check all that apply)

spouse/partner *parent(s)* *sibling(s)* *child(ren)*
 friends *co-workers/employer* *extended family* *other*

Has there been a time when you did not have this problem? *Yes No* *If yes, when?*

What resources or supports do you have to help solve the problem? (Check all that apply)

spouse/partner *child(ren)* *friends* *parent(s)*
 siblings *extended family* *co-worker(s)* *other*

I/we will know that counseling is finished when:

Goals are met
 I/we want to try things on my/our own

Signature of person completing the Information Form Date

Signature/Credentials of Counselor _____