Personal Information Form
Confidential

Today's Date: _____
Full Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____Cell: _____
Phone: Home: _____ Work: _____SS#: _____
Email Address: _____ Sexual Identity: _____
Racial Identity: _____Gender Identity_____
Referred by: _____
Name of Church: _____ Denomination: _____
Occupation: _____
Degree(s): Grades Completed: _____ Bachelor's: _____ Master's: _____Other: _____
Spouse's first name: _____
Number of children: _____ Names and age(s): _____
_____
Have you been in counseling? If yes, please provide details.
_____
_____
_____
Briefly describe what brings you here.
_____
_____

Check the issues that pertain to you: rate degree of stress/urgency for applicable areas, 1 (low) to 5 (high).

___Depression	___Chronic Illness	___Sexual Identity Issues
___Marital Problem	___Occult	___Anger
___Drug Addictions	___Insomnia	___Physical Abuse
___Eating Disorder	___Alcoholism	___Sexual Abuse
___Grief/Loss	___Low Self-Esteem	___Emotional Abuse
___Occult Oppression	___Career Decision	___Relationships
___Workaholism	___Financial Crisis	___Loneliness
___Unforgiveness/Bitterness	___Excessive Anxiety/Fear	___Spiritual Issues/Concerns
___Sexual Concerns	___Thoughts of Suicide	___Thoughts of Harm/others

Other:

Are you under a doctor's care? _____ If yes, Doctors Name_____
Please share what you are being treated for and any medications you are currently taking.
_____
_____
_____
_____
In Case of Emergency, whom would you like to be contacted?
Name/Relationship_____Phone: _____