ADULT COUNSELING INFORMATION SHEET Grace For All Families, LLC

Date _______

Name ______________________ **Age** ___ Date of Birth __/__/__

Spouse's Name _____________________ **Age** ____

Address ______________________________________ City ____________ Zip ______

Email ____________________________________

Phone (primary) __________________ Other ____________________

Place of Employment ___________________ Phone ____________

Emergency Contact (name) _________________ (relation to you) __________________

Emergency Contact's phone number ___________________________

Referred by: Friend/Family member (please list name) ___________________________

Church ________________ Internet/other ___________

Faith background ___________ If applicable, list church name _____________________

Marital Status: Single __ Married__ Divorced__ Widowed__ Separated ___

If divorced or separated, how long? ______________________

If married, is this your first marriage? Y/N Comments ___________

If applicable, do you wish for your spouse to join you in counseling? Y/N/NA

Comments: ____

Family Info Father's Name__________________ Mother's Name __________________

Names/Ages of Children (you may include stepchildren and children not in household)

1. ________________________ Age ___
2. ________________________ Age ___
3. ________________________ Age ___
4. ________________________ Age ___
5. ________________________ Age ___
6. ________________________ Age ___

Names/Ages of Siblings (Please list in order of age)

1. ________________________ Age ___
2. ________________________ Age ___
3. ________________________ Age ___
4. ________________________ Age ___
5. ________________________ Age ___
6. ________________________ Age ___

Counseling/Mental Health Background

Have you received counseling before? Y/N Where? __________________________

What issues were addressed? _______________________________ # of visits? _______

Are you currently on any medication for anxiety, depression, or addiction medicine, or other? Y/N If yes, what prescription(s)? ____________________________________

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Do you have an addiction? Y/N Comments ___________________________________

Have you experienced any previous trauma? (to include sexual, physical, verbal, mental, etc) Y/N Comments ____

Please rate the following – 1 is low and 5 is high:

Physical Health: ___ Comments: ____

Spiritual Health: ___ Comments: ____

Mental Health: ___ Comments: ____

Goals: What goals do you wish to accomplish in counseling? ______________________

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In order to understand me: ____

What really hurts me: ____

I wish I could change: ____

My greatest regret is: ____

My greatest fear is: ____

My greatest joy is: ____

Additional Comments: ____