Personal Information Form

WHOLENESS TO FREEDOM MINISTRIES INC.
Susan E. Begley, LMHC, CETP; License MH #11717
1619 Ferndale Avenue, Melbourne, Florida 32935
Phone: 321-604-9078 email: sbegley@wholenesstofreedom.org

Identification Information: Intake Date: ____________

Name: ____ Phone: ________________

Address: ____

Billing Address *(if different from above):* ____

E-mail: __________________________ Birth Date: _____________ Gender: ☐ Male ☐ Female

Race/Ethnicity ________________ Religion/Spirituality ____________________

Marital Status: ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Living Status: ☐ Independent ☐ Dependent - Relative ☐ Dependent – Friend ☐ Assisted Living ☐ Homeless

Education Status: ☐ Full-time Student ☐ Part-Time Student ☐ Non-Student

Highest grade completed: _______ Name of School: ____________________________________

Employment Status: ☐ Full-time ☐ Part-Time ☐ Unemployed ☐ Disabled ☐ Other: ____________

Occupation: _______________ Work Phone: ___________ Job Satisfaction __________________

Financial Situation: ☐ No current problems ☐ Large indebtedness ☐ Poverty or below-poverty income ☐ Impulsive spending ☐ Relationship conflicts over finances ☐ Other: _________________

Emergency Contact Information:

Name: __________________________ Phone: ________________ Relationship: ______________

Address: ____

How were you referred to our office? ____

At times we may need to contact you in order to reschedule an appointment, provide a reminder, and/or provide some medical information. May we contact you? ☐ Yes ☐ No

How would you like us to contact you? ☐ Phone Call ☐ Text ☐ E-mail ☐ Letter ☐ Other: __________

Can we leave a message for you ☐ Yes ☐ No

If so at what phone number: __________________________________

Reason for Seeking Counseling:
State the nature of your problem in your own words for which you are seeking counseling.

____

____

How long has this issue existed? ____

What is your most difficult relationship right now? ____________________

What is your most difficult emotion right now? ______________________

Common problem / symptom checklist.

Rate each of the following life issue with the following **key: no issue=0; mild issue=1; moderate issue=2; severe issue=3.**

___Marriage	___Divorce/separation	___Alcohol/drugs	___God/faith
___Pre-marital	___Child custody	___Other addictions	___Church/ministry
___Being single	___Family	___Children	___In-laws
___Disabled	___Past hurts	___Money/budgeting	___Stress control
___Sexual issues	___Depression	___Anger control	___Loneliness
___Codependency	___School/learning	___Communication	___Weight control
___Grief/loss	___Fear/anxiety	___Parents	___Adult children
___ Work/career	___Intimacy	___Aging/dependency	___Health

Personal Information Form

Immediate Family Information

Spouse/Partner Name: ______________________________________ Home Phone: ____________

Spouse/Partner Address: ____

Spouse/Partner Birth Date: _______________ Gender: ☐ Male ☐ Female

Education Status: ☐ Full-time Student ☐Part-Time Student ☐ Non-Student

Highest grade completed: _______ Name of School: ________________________________

Employment Status: ☐ Full-time ☐Part-Time ☐ Unemployed ☐ Disabled ☐ Other: __________

Occupation: ____________________ Work Phone: _____________

Length of Relationship: _____________ Age relationship began: Self: _____ Partner: _______

Is your partner willing to come for counseling? ☐ Yes: ☐ No ☐ Uncertain

Give brief information about any previous significant relationships: _____________________

____

____

Information About Children:

How many children? ___ Are your children: Biological ____ Adopted ____ Partner's Children ______

NAME	AGE	SEX	EDUCATION LEVEL	RESIDENCE

Health Information

Rate your health: ☐Very Good ☐Good ☐Average ☐Poor: ____

Weight changes recently: ☐None ☐Lost ☐Gained: ____

List all important present or past illnesses, injuries, or disabilities: __________________________

____

____

Physician's name: _________________ Address: ____

Date of last medical exam: ___________________ Report: ________________________________

____

Are you presently taking medication? ☐ Yes ☐No If yes list the medication and dosage:

MEDICATION	DOSAGE	TIMES PER DAY	REASON FOR TAKING

Personal Information Form

Have you ever had any counseling before? ☐ Yes ☐No (If yes please fill in the dates, diagnosis, who treated you.)

DATE	DIAGNOSIS	PROVIDER

Have you ever been abused: Physically ◯ Yes: ◯ No; Emotionally ◯ Yes: ◯ No; Sexually ◯ Yes: ◯ No

Spiritually ◯ Yes: ◯ No Age?_____ By Whom? ____________________

Have you ever had suicidal thoughts? ☐ Yes: ☐ No Have you ever had suicidal intentions? ☐ Yes: ☐ No

Have you ever attempted suicide? ☐ Yes: ☐ No Age?____ Method? ____________________

Have you ever had homicidal thoughts? ☐ Yes: ☐ No Have you ever had homicidal intentions? ☐ Yes: ☐ No

Have you ever attempted homicide? ☐ Yes: ☐ No Age?____ Method? ____________________

Have you ever been Baker Acted? ☐ Yes: ☐ No If so, by whom: ____________________

Age(s) _____________ Length of stay ______________________

Have you used drugs for other than medical purposes? ☐ Yes ☐No If yes, check all that apply

Substance	Yes	No	Past	Substance	Yes	No	Past	Substance	Yes	No	Past
Alcohol	☐	☐	☐	Pain pills	☐	☐	☐	Marijuana	☐	☐	☐
Tranquilizers	☐	☐	☐	Stimulants	☐	☐	☐	Inhalants (glue)	☐	☐	☐
Sleeping pills	☐	☐	☐	Narcotics	☐	☐	☐	Other:	☐	☐	☐
Hallucinogens	☐	☐	☐	Methadone, Heroin	☐	☐	☐	Other:	☐	☐	☐

Have you ever been Marchman Acted? ☐ Yes: ☐ No If so, by whom: ____________________

Age ____ Treatment ____________________

Legal History: ☐ No legal problems: ☐ now on parole/probation ☐ arrest(s) not substance-related

☐ Arrest(s) substance-related ☐ court ordered this treatment ☐ Jail/prison _____time(s)

☐ Total time served _______ ☐ Describe last legal difficulty: ____________________

Cultural/Religious/Spiritual Background:

Do you have any significant cultural, religious, or spiritual practices that are important to you? If so, briefly explain: ____________________

____

Client Signature: ____________________ Date: ________________

Counselor: ____________________ Date: ________________