



Personal Information Form

WHOLENESS TO FREEDOM MINISTRIES INC.

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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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stimulants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inhalants (glue)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Narcotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinogens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Methadone, Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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: _____