James L. Begley Jr. M-DIV, BCPC
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Personal Information Form

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

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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

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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: _____