

Shoals Counseling

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Client Personal Profile Form

Name: _____ Sex _____ Birth Date _____

Phone #'s: _____ Home _____ Cell _____ Work _____

Email _____

Address _____

(Include street, city and zip)

Marital Status: S M D W

Religion _____ Referred By: _____

DIRECTIONS: Please answer the following questions as fully as possible.

Present Problem – “These are issues causing me stress.” Please circle all that apply:

Marital issues

Health issues

Job issues

Financial issues

Parent/child issues

Issues of past (guilt, abuse, neglect, family of origin issues)

Other _____

Symptoms: Please circle all that apply:

Change in sleep pattern

Decreased concentration

Change in appetite

Increased anxiety

Decreased energy

Decreased motivation

Circle any losses you have experienced:

Family

Health

Disruption of lifestyle, job, significant other

Other _____

Suicidal/Homicidal Ideation

Have you attempted to commit suicide or homicide in the past? (Circle: Yes or No)

If yes, how? _____

Is there a history of suicide in your nuclear and/or extended family? (Circle: Yes or No)

Have you ever inflicted burns or wounds to yourself? (Circle: Yes or No)

Are you presently suicidal/homicidal? (Circle: Yes or No)

What event(s) in the recent past has/have prompted you to seek counseling?

How do you expect counseling to help your present situation (what are your goals)?

Would it be beneficial for any members of your family to be involved in your counseling?

(Circle: Yes or No)

If yes, please explain: _____

List your strengths and weaknesses:

Strengths

Weaknesses

Strengths	Weaknesses
_____	_____
_____	_____
_____	_____

Living Arrangements

Satisfactory Unsatisfactory: How long there? _____ With whom are you living?

Support System

Who can you count on for support? Circle as many as apply.

Parents, Spouse, Siblings, Employer, Church Pastor, Therapist, Neighbor(s),
Close friend, Extended family, Small/Support Group, Community Services,
Co-Worker, Medical Doctor

Other: _____

Please list any past difficulties in the area of religious or ethnic/cultural background:

Do you currently attend church? (Circle: Yes or No) If yes, where? _____

Marriage & Family History (if applicable):

What is your perception of your current marriage (include communication problems): _____

When were you married? _____ Name & age of spouse: _____

Any children from current marriage? (Circle: Yes or No)

Previous marriage/s? (Circle: Yes or No) If yes, date/s of divorce: _____

Any children from that/those marriage/s? (Circle: Yes or No)

Have you ever been to counseling as a result of the problems with this relationship prior to today?
(Circle: Yes or No)

If so, what was the outcome of that counseling? _____

Have either of you or your partner struck, physically restrained, used violence against or injured the other person within the last three years? (Circle: Yes or No)

What has been the frequency of sexual relations during the last month? _____ or year? _____

Are the numbers above a reflection of a change in the history of your sexual relations? If so, please describe why your sexual intimacy has changed:

To what degree do the two of you share similar values in regards to gender roles? (Circle one)

Extremely high very high high moderate low very low extremely low

To what degree do the two of you share similar values in regards to religion? (Circle one)

Extremely high very high high moderate low very low extremely low

To what degree do the two of you share similar values in regards to finances? (Circle one)

Extremely high very high high moderate low very low extremely low

To what degree do the two of you share similar values in regards to divorce? (Circle one)

Extremely high very high high moderate low very low extremely low

What is your current level of marital stress? (Circle one)

Extremely high very high high moderate low very low extremely low

To what degree do you have family or friends that support you as a couple? (Circle one)

Extremely high very high high moderate low very low extremely low

List names and ages of your children. How do you get along with each one? Problems?

Name	Age	Comment
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Developmental History

List the members of your family of origin and how you got along with each one.

Family Member

Comment

What was your birth order? ___ of ___ children.

Who primarily raised you? _____

How would you describe your childhood? (Circle one)

Wonderful Positive Traumatic Painful Uneventful

What were you like as a child (include friends, school, hobbies, and personality)? _____

Were there any unusual or traumatic experiences for you as a child?

Date Age Event

What is your sexual orientation? (Circle one) Heterosexual Homosexual Bisexual

Work Adjustment History

Place of Employment _____ Position _____

What do you like/dislike about your current employment/career? Please list:

Like	Dislike
_____	_____
_____	_____
_____	_____

Do you plan on staying at this job? _____ How many jobs have you held within the previous five years? _____ If you could choose any job, what would it be? _____

Describe your relationship with your superiors and co-workers? _____

Describe your job performance: _____

Have you ever been fired? (circle: Yes or No) If yes, please explain: _____

Educational History

What was school like for you? _____

Highest level achieved _____ What types of grades did you make? _____

Currently in school? (circle: Yes or No) If yes, what level? _____

Treatment History

Please list any previous outpatient counseling experiences:

Counselor _____ Dates of treatment - from _____ to _____

Reason for counseling: _____

Counselor _____ Dates of treatment - from _____ to _____

Reason for counseling: _____

Please list any admissions to the hospital for mental health or addiction issues:

Place of treatment _____ Dates of treatment - from _____ to _____

Reason for treatment: _____

Place of treatment _____ Dates of treatment - from _____ to _____

Reason for treatment: _____

List all medications you have taken in the past for anxiety, depression, and/or sleep: _____

Medical Information

Please describe your current condition of health: _____

Are you currently on any medication? (Circle: Yes or No) Please include the name of the

Medication/s and the prescribing physician _____

Has it been more than a year since your last physical including blood tests? (Circle: Yes or No)

Do you have any allergies? (Circle: Yes or No) If yes, explain _____

List any previous health problems, operative procedures, and medical hospitalizations:

Problem	Dates	Treatment
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Substance Abuse/Addiction History

Is there a substance or activity that you are potentially dependent on?

Describe your current usage or usage in the past of this substance or activity (including alcohol, tobacco, shopping, working out, gambling, etc).

Have you experienced a recent increase in the use of alcohol/other substances? (Circle: Yes or No)

Do you see your current usage as a problem? (Circle: Yes or No) If yes, when did it become problematic? _____

Describe any significant family history of substance abuse:

Nutrition

Have your eating habits changed recently? (Circle: Yes or No) If yes, please describe: _____

Has your weight fluctuated more than +/- 10 lbs. over the previous year? (Circle: Yes or No)

Do you often eat out of depression, boredom, anger? (Circle: Yes or No) If yes, please describe _____

If you use laxatives, water pills (diuretics), or diet medications, how often do you use them?

Legal History

(Please explain all that apply)

Charges as a minor, Charges presently, Arrests, Convictions, Parole or Probation, Bankruptcy, Civil Suits, Child Custody Problems: _____

Military History

List branch, dates, and duties:

Technology Use

Estimate how many hours a day you spend online:

Facebook _____ YouTube _____ Gaming _____ Browsing _____ Texting _____

Work/School _____ Other _____

Do you feel your technology use is balanced and healthy, or could it be improved? Please explain:

Miscellaneous

Are there any other things that can be helpful for me to know about you? _____

I affirm by my signature that I have personally provided accurate information to all the questions contained in this personal profile form.

Signature: _____ Date: _____