



## PERSONAL PROFILE FORM

Name: \_\_\_\_\_ Sex \_\_\_\_\_ Birth Date \_\_\_\_\_

Phone #'s: \_\_\_\_\_ Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Email \_\_\_\_\_

Address \_\_\_\_\_  
(Include street, city and zip)

Marital Status: S M DW Religion \_\_\_\_\_ Referred By: \_\_\_\_\_

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Daymark Pastoral Counseling sends out a quarterly newsletter that contains short articles, book reviews and news about the ministry.

\_\_\_\_\_ Yes, send me the newsletter. \_\_\_\_\_ No, I would not like to receive the newsletter.

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**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 you strengths and 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: \_\_\_\_\_

Previous marriage? (circle: Yes or No) If yes, date of divorce: \_\_\_\_\_ Any Children from that marriage: \_\_\_\_\_

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 the last month \_\_\_\_times or Year? \_\_\_\_times  
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: \_\_\_\_\_

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

Extremely high      very high      high      moderate      low      very low      extremely

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

Extremely high      very high      high      moderate      low      very low      extremely

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

Extremely high      very high      high      moderate      low      very low      extremely

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

Extremely high      very high      high      moderate      low      very low      extremely

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

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

Name	Age	Comment

### **Developmental History**

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

<u>Family Member</u>	<u>Comment</u>



**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 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:

<u>Problem</u>	<u>Dates</u>	<u>Treatment</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**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:

**Miscellaneous**

Are there any other things that can be helpful for us to know about you? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**