Central DuPage Pastoral Counseling Center

CLIENT CONFIDENTIAL INFORMATION PACKET

Name:_____ Date:_____

The main reason I came for counseling at this time:_____

_____

_____

_____

(If married, in addition to putting a check mark next to all the issues that concern you, please put your spouse's initials next to issues that pertain to him/her.)

Individual Concerns:

_____Nerves
_____Shyness
_____Drug use
_____Anger
_____Stress
_____Headaches
_____Memory
_____Loneliness
_____Career choices
_____Temper
_____Bowel problems
_____ Addiction
_____ Pornography

_____Depression
_____Suicidal thoughts
_____Alcohol use
_____Self Control
_____Relaxation
_____Tiredness
_____Making Decisions
_____Inferiority feelings
_____Health problems
_____Appetite/weight
_____Stomach trouble
_____ Bingeing
_____ Purging

_____Fears
_____Finances
_____Friends
_____Sleep
_____Work
_____Legal Matters
_____Ambition
_____Concentration
_____Education
_____Dreams
_____Thoughts
_____ Cutting /burning body
_____ Body Image

Relationship Concerns:

_____Closeness
_____Scheduling conflicts
_____Communication
_____Friendships
_____Verbal fighting
_____Common interests
_____Spouse's cleanliness
_____Common goals
_____Flirting behavior
_____Holding each other down
_____Other:_____

_____Sexual desire
_____Sexual Performance
_____Relatives
_____Jealousy
_____Physical fighting
_____Recreation
_____Showing Appreciation
_____Trusting each other
_____Parenting

_____Affection
_____In-laws
_____Finances
_____Recreation
_____ Infidelity/Affairs
_____Housing
_____Agreeing on chores
_____Having fun together
_____Solving problems

_____

Developmental History

Infant History: (0–2) (prenatal experience, delivery traumas, early illnesses, significant events)

_____

_____

Childhood History (2 - 6) (developmental milestones, significant events, relationships, how I felt about myself and others)

_____

_____

School History: (6–12) (first days, attendance, achievement, significant relationships, perception of school)

_____

_____

_____

Adolescent History: (12–18) (social relationships, sexual development, dating, significant memories)

_____

_____

_____

_____

Adulthood History (18 +) (academic pursuits, vocational training, career directions and goals, marriage and family life, significant memories)

_____

_____

_____

_____

_____

Please check off and explain if any of the following applies to you or a family member:

☐ Conviction ☐ Probation ☐ Prison sentences ☐ DUI's ☐ Domestic violence
☐ Homicide ☐ Suicide ☐ Cult involvement ☐ Child/Spouse Abuse
☐ None of these (*explain)*_____

_____

_____

Medical History

Name of Primary Care Physician:_____

Phone Number of Primary Care Physician:_____

Name of Psychiatrist:_____

Phone Number of Psychiatrist:_____

Have you or your family had problems with any of the following?

Issue	Person	Problem: (Date & Severity)
Alcohol		
Drugs		
Other medications		
Diseases		
Significant Accidents including Head Injury		
Pregnancies/Miscarriages		
Sleep Apnea/Insomnia		
Depression/Bipolar/ Seasonal Affective Disorder		
Anxiety		
Hospitalization		
*(indicate if psychiatric)		
Outpatient care or therapy		
*(indicate if psychiatric)		

Other _____

_____

Please list all medications you are currently taking, dosage and frequency:_____

_____

_____

Also, please indicate how your parents & grandparents died, if applicable_____

_____

Family History

Family of origin (in which I grew up)
(*Use additional paper if necessary)*

Names	Relationships	Ages	Education	My attitude towards them

Family with whom I live now:
(*Please provide the same information as above)*

Significant family events and/or childhood traumas:

Relationship with spouse (ex-spouses)

Name	Length of Dating	Date of Marriage	Length of Marriage	My attitude towards spouse

Coping Skills

I practice the following:

_____Take time for myself

_____Spend time outdoors with nature

_____Meditate regularly

_____Attend a public worship in my denomination

_____Regularly involve myself in physical exercise

_____Regularly read and develop myself spiritually or psychologically

_____Feel like I can tackle challenges that surround me

_____Have one or more deep intimate friends

_____Am involved with a group of friends recreationally

_____Eat three healthy meals a day

_____Sleep soundly and regularly

_____Do not smoke

_____Do not drink to excess or have more than three drinks per week

_____Handle stress well

_____Review my life goals

_____Am not overweight

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Intentionally

Sentence Completion

1. I like_____
2. The happiest time_____
3. I want to know _____
4. Back home_____
5. I regret_____
6. At bedtime_____
7. Men_____
8. The best_____
9. What annoys me_____
10. People_____
11. A mother_____
12. I feel_____
13. My greatest fear_____
14. In school_____
15. I can't_____
16. Sports_____
17. When I was a child_____
18. My nerves_____
19. Other people_____
20. I suffer_____
21. I failed_____
22. Reading_____

Sentence Completion

23. My mind_____

24. The future_____

25. I need_____

26. Marriage_____

27. I am best when_____

28. Sometimes_____

29. What pains me_____

30. I hate_____

31. This place_____

32. I am very_____

33. The only trouble_____

34. I wish_____

35. My father_____

36. I secretly_____

37. I_____

38. Dancing_____

39. My greatest worry_____

40. Most women_____

41. My greatest fantasy is_____

42. Jesus Christ_____

43. A good therapist_____