Name of Client: _____

Tree of Life Counseling – Biographical Information Form

To assist in helping you, please fill out this form as filly and openly as possible. All private information is held in the strictest of confidence within legal limits. If certain questions do not apply to you, leave them blank. Thank you for taking the time to provide this important information. We hope that this visit, and all future visits, will meet your expectations.

Personal History

Name _____ Gender _____

Address _____

Date of Birth _____Home Phone _____ Cell Phone _____

Education Level _____ Occupation _____

Employer _____ Work Phone _____

Ethnic/Cultural Background _____

Marital Status* _____ Name of Spouse _____ Spouse DOB _____

*Single (never married), Engaged, MF (first marriage), MN (married not first time), Separated, Divorced, Widowed

Number of Children _____ Name/Ages of Children _____

With whom does each child live? _____

Emergency Contact Person _____ Relationship _____

Best Telephone Number of Emergency Contact _____

Counseling History

Are you receiving counseling services elsewhere at present? YES NO

If yes, please describe briefly _____

Have you ever received counseling in the past?

Outpatient? YES NO Inpatient? YES NO

If yes, please describe briefly _____

What is your main reason for this visit? _____

_____

How long has the reason mentioned persisted? _____

Are there conditions under which the situation is better, and/or situations when it is worse? _____

How did you learn of the services of Tree of Life Counseling? _____

Name of Client: _____

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Medical History

Name and address of General Physician _____

_____

When was your last physical exam _____

List any major illnesses and/or operations which you have had _____

_____

List any physical concerns (e.g., high blood pressure, headaches, diabetes, hypoglycemia)

_____

_____

List any other physical concerns that you have had in the past year _____

_____

_____

On average, how many hours of sleep do you get each night? _____

Are you taking any medications at present? If so, for what purpose?

_____

_____

Religion

What is your family's religious affiliation? _____

Name of Church _____

How important is religious commitment to you? _____

Have you had any negative experiences with religion? If yes, please explain.

_____

_____

Do you desire to have religious beliefs and values incorporated into your counseling?

Yes _____ No _____ Not Sure _____

Please explain _____

_____

Name of Client: _____

Tree of Life Counseling – Biographical Information Form

Areas of Concern

Please rate each one of the following concerns as they apply to you *at the present time* on a scale of 1-5 (**1 = not a problem, no concern; 5 = severe problem, strong concern**)

Feelings of sadness, crying, being "down"	1	2	3	4	5
My mind feels like it's racing	1	2	3	4	5
Unwanted thoughts in my mind	1	2	3	4	5
Sometimes I can't control what I do	1	2	3	4	5
Sleep problems	1	2	3	4	5
Feeling worthless	1	2	3	4	5
Problems with anger/temper	1	2	3	4	5
Feeling like things aren't real	1	2	3	4	5
Problems with my eating	1	2	3	4	5
There are things too painful to talk about	1	2	3	4	5
Concerns about my sexuality	1	2	3	4	5
Use of alcohol and/or drugs	1	2	3	4	5
Doing things over and over	1	2	3	4	5
Seeing or hearing things that others don't	1	2	3	4	5
Feeling anxious/nervous	1	2	3	4	5
Being close to people	1	2	3	4	5
Spiritual concerns	1	2	3	4	5
Pain and/or health concerns	1	2	3	4	5

Are there any past or current relationships that are a particular concern to you? Please describe briefly _____
_____

What are the most significant stresses you are currently dealing with? _____
_____

What do you consider to be your most important strengths? _____
_____

Current hobbies and interests? _____

Are there other areas of concern that you would like your counselor to know about which have not been covered in this questionnaire? _____
_____