River House MINISTRIES, INC. Biblical Counseling & Education

<u>Instructions</u>*: Please complete this as accurately as possible, including any information you feel could benefit the counseling process. All information contained in this survey is confidential except as prohibited by state/federal law regarding major criminal offenses and child, elderly, and disabled persons abuse.*

Personal Information

Name_____ Birthdate_____ Date_____

Street Address_____

City_____State_____ZIP_____

Email_____

Phone #_____

Employer_____

Current profession_____

Education Highest grade or degree completed_____

Marital Status: single ☐ married ☐ divorced ☐ widowed ☐ remarried ☐

Living together/cohabitating ☐

In your current relationship:

Does your spouse/partner know that you have come here for counseling? _____

Would your spouse/partner come for counseling? _____

Have you separated or filed for divorce? _____

<u>Emergency Contact Information</u>

In case of an emergency contact:

Name_____Relationship_____

Address_____

Phone (cell) _____ (work) _____

Reason for seeking counseling: What specific issues(s) in your life are you hoping will be addressed through the counseling process?

_____

_____

Select the words to describe **why you need counseling**:

Grief ☐	Depression ☐	Anxiety ☐	Nervousness ☐	Fear ☐
Self-doubt ☐	Guilt ☐	Suicidal thoughts ☐	Loneliness ☐	Marriage problems ☐
Sexual concerns ☐	Impotency ☐	Homosexuality ☐	Adultery ☐	Compulsive lust ☐
Loss of hope ☐	Loss of meaning ☐	Loss of self-respect ☐	Loss of love ☐	Bitterness ☐
Anger with God ☐	Religious doubts/fear ☐			
Relationship;	with parents ☐	with children ☐	with spouse ☐	with others ☐
Loss of faith;	in God ☐	in self ☐	in others ☐	

Have you been in counseling or therapy before? Yes ___ No___
If yes, was it helpful? Why/Why not? _____

List dates, counselors, and problems:

_____

Physical Health

Rate your health: poor___ fair_____ average____ good____

Date of last medical exam: _____ Do you drink caffeine? ____ Do you smoke? _____
How much a day? _____ Do you use drugs? _____

If yes, what, and how often?_____

Please list your allergies: _____

Please indicate your pregnancy history by selecting all that apply:

Abortion_____ Adoption_____ Miscarriage____ Stillbirth_____

List all major illnesses/injuries/disabilities:

_____

_____

Has your weight changed more than 10 lb. in the past few months? Yes __ No___
Have you Gained ___ Lost___ How much? ___

Family Background

Parents:
Are your parents living? mother: yes ___ no___ father: yes___no___
Are they living together? yes ___no___
Are they divorced? yes ___no___ If yes, how old were you when they divorced? _____
Are they remarried? mother __ yes __no father __yes ___no

Was your relationship with your mother: ___close ___ distant ___ conflicted
Was your relationship with your father: ___close ___ distant ____ conflicted

Please list siblings:

Name (optional)	Gender	Age	Living in the home
1) _____	_____	_____	_____
2) _____	_____	_____	_____
3) _____	_____	_____	_____
4) _____	_____	_____	_____
5) _____	_____	_____	_____

Where do you fall in the birth order? _____

How was your relationship with your siblings growing up? close ___ distant ___ conflicted
Was yours a basically happy or unhappy home during childhood?
_____

Were there any instances of abuse in your family?

			By whom?	Abuse directed toward?
Verbal	____ Yes	____ No	_____	_____
Emotional	____ Yes	____ No	_____	_____
Physical	____ Yes	____ No	_____	_____
Sexual	____ Yes	____ No	_____	_____
Alcohol	____ Yes	____ No	_____	_____

Drugs	____ Yes	____ No	_____	_____
Compulsive habits	____ Yes	____ No	_____	_____

Other problems not mentioned

_____

_____

Spiritual History

Note: The counseling provided will be conducted from a faith-based perspective. While the counselee does not have to be of the Christian faith, they understand that issues of faith will be an important component of the counseling process.

What is your religious or church background?

_____

Are you currently active in your church? If so, which church are you affiliated with?

_____

How would you describe your relationship with God?

_____

_____

_____

_____

Mood Inventory

Do you have any of the following symptoms:

	Yes	No
1. Change in eating habits (poor appetite/overeating)?	_____	_____
2. Change in sleeping patterns (insomnia/oversleeping)?	_____	_____
3. Have a lack of motivation/energy for ordinary tasks?	_____	_____
4. Have feelings of hopelessness?	_____	_____
5. Have ever thought of harming yourself or someone else?	_____	_____
6. Have you ever been diagnosed with:		
Depression	_____	_____
Schizophrenia	_____	_____
Obsessive-compulsive disorder	_____	_____
attention deficit disorder	_____	_____
anxiety disorder	_____	_____
Bipolar	_____	_____
other (please describe) _____	_____	_____
7. Have you personally ever received psychiatric treatment?	_____	_____
8. Has any member of your family ever received psychiatric treatment?	_____	_____
If yes, who and what was the diagnosis:_____		
9. Feel mentally confused?	_____	_____
10. Self-medicate (through alcohol, sex, food, work, entertainment, etc.)?	_____	_____

11. Have short-term memory loss? _____ _____
12. Have panic attacks? _____ _____
13. Hear voices that others do not? _____ _____
14. Are you now undergoing psychiatric treatment? _____ _____
15. Are you currently on medications? _____ _____

If so, which ones?

_____

Addiction Inventory

Have you ever been addicted to any of the following:

	Currently		In the Past	
Alcohol	Yes ____	No _____	Yes ____	No _____
Substances	Yes ____	No _____	Yes ____	No _____
Tobacco	Yes ____	No _____	Yes ____	No _____
Food	Yes ____	No _____	Yes ____	No _____
Gambling	Yes ____	No _____	Yes ____	No _____
Pornography	Yes ____	No _____	Yes ____	No _____
Sex	Yes ____	No _____	Yes ____	No _____

Other (please list) _____

Has anyone in your family been addicted to any of the above? _____

If yes, which ones and what is your relationship to them? _____

Have you been in the military? ☐ yes ☐ no If yes, were you in combat? ☐ yes ☐ no

Personal Inventory

Describe yourself in as many one or two-word phrases as possible:

1) _____ 2) _____

3) _____ 4) _____

5) _____ 6) _____

7) _____ 8) _____

Additional Information

Please describe any additional information that you feel is important to the counseling process.

_____

_____

_____

_____

Miscellaneous Information

If referred here, by whom? _____

Name (Nickname-if specific request)_____

Payment Information

Payment for counseling services is due upon receipt of services. I will be charged the full fee to my credit card on file for appointments canceled with less than 24-hour notice.

_____ _____

Signature Printed Name

_____

Date