BRIDGE MINISTRIES
Spanning the Gap with Grace & Truth

COUNSELING PERSONAL INFORMATION FORM

All information provided will be strictly confidential, as discussed in the Counseling Agreement.

Basic Information

Name: _____

Address: _____

City, State, Zip: _____

Date of Birth: _____

Home Phone: _____

Cell Phone: _____

Occupation: _____

Employer: _____

Work Phone: _____

Education: _____

Email Address: _____

Emergency Contact: _____

His/Her Phone: _____

Who referred you to Bridge Ministries? _____

Are you currently suicidal? _____

Do you feel like you might be unsafe to yourself or others? _____

Religious Background

How many times per month do you attend a church worship service that includes a sermon?

_____

What church do you attend? _____

Do you consider yourself a religious person? _____

Do you believe in God? _____

Do you pray to God? _____ How often? _____

Do you read the Bible? _____ How often? _____

Do you consider yourself 'saved'? _____

How did you come to your faith? _____

If you were to die and stand before God and He asked you why He should permit you to enter heaven,

how would you respond? _____

_____

_____

_____

_____

Family Information

What is your marital status? _____

If not married, do you presently have a relationship with another person? Please explain.

_____

_____

If married, when was your wedding? _____

Have either you or your spouse been married before? _____

When did you and your spouse or significant other meet? _____

Have you ever been unfaithful to your partner? _____

If not married, do you engage in premarital sex? _____

Does anyone beside yourself currently live with you? Please list their names, ages, and their relationship to you:

Name Age Relationship

_____

_____

_____

_____

_____

_____

_____

If you have children, were any of them not a product of your current relationship? _____

_____

Briefly describe your family upbringing. _____

_____

_____

_____

_____

Medical History

What is the name, address, and phone number of your primary care physician?

_____

_____

When was the last time you saw your doctor? _____

When was the last time you had a medical physical which included labs? _____

Are you currently under the care of any other doctor, besides your primary care physician? Is so, please list their name(s) and specialty(s). _____

_____

List the names and doses of any medications you are currently taking, including herbs and supplements.

Name Dose Reason

_____

_____

_____

_____

_____

_____

_____

_____

Have you ever used prescription drugs for anything beyond their prescribed medical purpose?

_____

Have you ever used illegal drugs? _____ If so, please list which drugs, what time period(s) you used them, and the date of the last time you last used.

Drug	Period	Last Used

If female, do you have regular menstrual cycles? _____

Have you ever non-accidentally viewed pornography? _____

If yes, when was the last time you viewed pornography? _____

Do you smoke or drink alcohol? If yes, how much and how often? _____

_____

Rate your overall health on a scale of 1 to 10, where 1 is the worst and 10 is perfectly healthy.

_____

Has your weight gone either up or down more than 15 pounds in the past three months? _____

_____

List all major illnesses, injuries, handicaps, or surgeries, with dates where applicable.

_____

_____

_____

_____

List any allergies you have. _____

_____

_____

How many hours of sleep do you get per night, on average? _____

Has this changed recently? _____

Do you feel that this sleep is sufficiently restful? _____

Have you or others noticed any changes in your personality (anger, mood swings, isolation, etc.), thinking, memory, or work habits? _____

_____

_____

Have you suffered the loss of someone close to you in the past year? _____

_____

Have you had any other significant life changes in the last year? If yes, explain. _____

_____

_____

_____

Personal History

Have you ever had counseling or psychiatric care in the past? _____

With whom, when, and why? _____

_____

_____

_____

Have you ever been diagnosed with a mental health condition? _____

_____

Have you ever purposefully caused yourself bodily harm? Please describe. _____

_____

_____

Have you ever attempted suicide? If so, when? _____

_____

Have you ever been convicted or a crime? If so, please describe the charges and in which year they occurred. _____

_____

_____

Do you have any legal action pending? _____

_____

Circle any of the following that you feel describes you now:

Poor appetite	Headaches	Health problems
Alcohol use	Drug use	Insomnia
Stomach troubles	Lethargy (tiredness)	Unsatisfied at work
Unsatisfied at home	Sexual problems	Calm
Easy-going	Excitable	Extroverted
Good-natured	Hard-working	Imaginative
Impulsive	Impatient	Intense
Introverted	Leader	Likeable
Moody	Persistent	Quiet
Self-confident	Self-conscious	Sensitive
Shy	Active	Ambitious
Angry	Distracted	Depressed
Anxious	Energetic	Fearful
Forgetful	Feel inferior	Lonely
Trouble making decisions	Nervous	Nightmares
Relaxed	In control	Unstable
Serious	Stressed	Submissive
Suicidal	Confused	Paranoid
Not able to concentrate	Guilty	Can't stop crying
Low self esteem	Tell a lot of lies	Have flashbacks
Grief	Feel nothing	Hopeful
Hopeless	Rapid thoughts	Lack of inhibitions