

PASTORAL THERAPY ASSOCIATES

DATE: _____

TYPE OF COUNSELING Sought:

___INDIVIDUAL

___COUPLE

___FAMILY

___OTHER

REFERRED BY: _____

IDENTIFICATION DATA:

NAME: _____ HOME PHONE: _____

ADDRESS: _____

_____ ZIP CODE _____

OCCUPATION: _____ BUSINESS PHONE: _____

DATE OF BIRTH: _____ HEIGHT: _____ WEIGHT: _____

SEX: M__ F__ RACE, NATIONAL OR ETHNIC ORIGIN: _____

RELIGIOUS AFFILIATION: _____

MARITAL STATUS: _____ HOW LONG: _____

ACADEMIC EDUCATION (NUMBER OF YEARS): _____

OCCUPATIONAL TRAINING: _____

MARITAL AND FAMILY DATA:

NAME OF SPOUSE: _____

SPOUSE'S DATE OF BIRTH: _____

ADDRESS: _____

_____ ZIP CODE _____

HOME PHONE: _____

OCCUPATION: _____ BUSINESS PHONE: _____

RACE, NATIONAL OR ETHNIC ORIGIN: _____

RELIGIOUS AFFILIATION: _____

ACADEMIC EDUCATION (NUMBER OF YEARS): _____

OCCUPATIONAL TRAINING: _____

CHILDREN OF THIS MARRIAGE:

NAME	AGE	GENDER	COMMENTS
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SOURCE OF INCOME: _____

YOUR INCOME BEFORE DEDUCTIONS: _____

SPOUSE OR FAMILY MEMBERS' WEEKLY INCOME: _____

TOTAL INCOME: _____

FEE (DETERMINED BY THERAPIST): _____

PREVIOUS MARRIAGES: YES NO

FORMER HUSBAND'S NAME(S)	PRESENT	DATE OF	COMMENTS
	AGE	MARRIAGE	

FORMER WIFE'S NAME(S)	PRESENT	DATE OF	COMMENTS
	AGE	MARRIAGE	

CHILDREN OF PREVIOUS MARRIAGE(S)

NAME	AGE	GENDER	PARENTS	COMMENTS
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PLEASE MAKE A FAMILY TREE/MAP:

HEALTH DATA:

RATE YOUR PHYSICAL HEALTH (CIRCLE ONE):

VERY GOOD AVERAGE POOR

LIST IMPORTANT ILLNESSES, SURGERIES OR INJURIES WHICH HAVE CAUSED SERIOUS DIFFICULTY:

DATE OF LAST MEDICAL EXAMINATION:

LIST OR DESCRIBE ANY MEDICATION AND DOSAGE NOW BEING TAKEN:

YOUR PHYSICIAN:

ADDRESS:

PHONE:

PREVIOUS COUNSELING, PSYCHOTHERAPY OR SPIRITUAL DIRECTION
(CIRCLE ONE): YES NO

IF YES, LIST NAME(S) OF COUNSELOR, THERAPIST OR DIRECTOR:

DATES AND NUMBER OF SESSION:

PREVIOUS SERIOUS MENTAL DISTURBANCE OR "NERVOUS BREAKDOWN"
(CIRCLE ONE): YES NO

IF YES, WERE YOU HOSPITALIZED? YES NO

ARE YOU NOW OR HAVE YOU EVER BEEN ABUSED?

ARE YOU NOW OR HAVE YOU PREVIOUSLY BEEN ALCOHOL OR DRUG
DEPENDENT?

RELIGIOUS AND/OR SPIRITUAL DATA

DO YOU CONSIDER YOURSELF RELIGIOUS?	YES	NO
DO YOU BELIEVE IN GOD?	YES	NO
DO YOU PRAY TO GOD?	YES	NO
DO YOU MEDITATE?	YES	NO
DO YOU READ SACRED SCRIPTURES (i.e., THE BIBLE, KORAN, COURSE IN MIRACLES, OTHER)?	YES	NO
HAVE THERE BEEN ANY CHANGES IN YOUR RELIGIOUS/SPIRITUAL LIFE RECENTLY?	YES	NO
HAVE YOU HAD ANY REMARKABLE SPIRITUAL EXPERIENCES?	YES	NO
HAVE YOU FELT EXTREMELY CLOSE TO GOD OR A DIVINE PRESENCE?	YES	NO

WHAT IS YOUR FAVORITE BIBLE OR RELIGIOUS STORY?

AS A CHILD?

WHAT IS YOUR FAVORITE MYTH OR FAIRY TALE?

AS A CHILD?

WHO IS YOUR FAVORITE HERO/HEROINE?

RELIGIOUS AFFILIATION IN CHILDHOOD?

BAPTIZED?

YES

NO

DO YOU ATTEND A CHURCH OR RELIGIOUS GROUP REGULARLY?

LIST PROBLEMS YOU WOULD LIKE TO DISCUSS IN THERAPY:

YOUR GOALS FOR THERAPY: