Pre-Counseling Profile

The following information will become part of your confidential file. This form helps us focus clearly on the areas of concern you may wish to address in counseling. Please answer each question as thoroughly and carefully as possible.

Name:____ Age: _______________

Date of Birth: ________________________ Sex: _________________

Address: ____

City: _______________________________ State: _________ Zip Code: _________________

Phone: __________________________ Alternate Phone: _______________________________

Occupation: ______________________________ Hours worked weekly: ____________________

Employer: ____

Presently living with (circle one): Parents | Spouse | Alone | Other: ________________________

Marital Status (circle one): Single | Married | Remarried | Separated | Divorced | Widowed

Educational Background

Circle the last year of school completed: Grade School 1 2 3 4 5 6 7 8 | High School 9 10 11 12 College 1 2 3 4 5 6+

Medical and Counseling Background

Describe any physical problems or conditions that may require medication or special care: _____
____

Are you currently receiving medical treatment? Yes | No. If yes, for what purpose? __________
____

Have you used drugs for non-medical purposes? Yes | No. If yes, what substances and with whom?
____

Have you received counseling, therapy, or mental health care before? Yes | No. If yes, when and for what reason? ____

Have you ever taken medication prescribed for emotional reasons? Yes | No. When and for what reason? ____

Are you currently taking medication for emotional or mental health reasons? Yes | No. If yes, please list the medication and reason: ____

Marital Background

Spouse's Name: ______________________________ Spouse's Occupation: ___________________
Is your spouse willing to participate in counseling? Yes | No | Unsure Date of marriage: _______

Ages when married: Husband __ Wife __ Have you ever separated? Yes | No. If yes, when?___

List all marriages (including current). Include your age at the time, duration, reason for separation (death/divorce/ other), and a brief explanation: ________________________________
____
____
____
____

List each child (name, age, sex, from which marriage, marital status, living at home, deceased; include age and cause of death if applicable): ____
____
____
____
____

Religious and Spiritual Background

Your denominational preference: ____________________________________ Active | Inactive

Spouse's denominational preference: _________________________________ Active | Inactive

Describe any significant spiritual experiences you have had or are currently experiencing: _____
____
____
____
____

Family Background

Natural parents: Married | Separated | Divorced. If separated or divorced, how old were you at the time? ____________

Father deceased? Yes | No. If yes, how old were you? _________________________________

Mother deceased? Yes | No. If yes, how old were you? _________________________________

Father remarried at your age: ___________ Mother remarried at your age: __________

You lived with: Mother | Father | Foster care | Other family member

Describe your relationship with any step-parents: ____
____
____

Father's occupation: ________________________ Mother's occupation: _____________________

Stepfather's occupation: _____________________ Stepmother's occupation: _________________

How many times was your father married? ______________ Your mother? ___________________

Rate your parents' marriage: Unhappy | Average | Happy | Very Happy
Their marriage lasted ___________ years.

List siblings (including step-siblings) from oldest to youngest, with names and ages:
____
____
____
____

Check all that describe your family history:

☐ Weak relationship with father/mother	☐ Close relationship with grandparents/aunts/uncles/cousins
☐ Weak relationship with siblings	☐ Alcohol/drug or other compulsive behavior by parents
☐ Sibling rivalry	☐ Addictive/compulsive behavior in other relatives
☐ Parent absent physically/emotionally	☐ Chronic illness (physical/mental/emotional) in family
☐ Moved frequently	☐ Rigid or perfectionistic standards
☐ Financial/job instability	☐ Frequent or excessive anger/conflict
☐ Relatives lived nearby	☐ History of physical, emotional, or sexual abuse

Current Problem Areas

Check any areas of current concern. Place two check marks beside those that are most significant. Add comments if desired.

☐ Abuse (childhood or adult) ____________________
☐ Addiction ____________________
☐ Anger ____________________
☐ Anxiety ____________________
☐ Bitterness ____________________
☐ Depression ____________________
☐ Eating disorder ____________________
☐ Educational concerns ____________________
☐ Family problems ____________________
☐ Fear ____________________
☐ Marital problems ____________________
☐ Physical problems ____________________
☐ Social relationship difficulties ____________________
☐ Parenting problems ____________________
☐ Religious/spiritual concerns ____________________
☐ Sadness ____________________
☐ Self-esteem ____________________
☐ Sexual concerns ____________________
☐ Stress ____________________
☐ Suicidal thoughts ____________________
☐ Trouble making decisions ____________________
☐ Substance abuse by others ____________________
☐ Work issues ____________________
☐ Worry ____________________
☐ Other: ____________________

Counseling Goals

Briefly describe the changes you would like to make in your life or relationships through counseling: ____________________

____

What do you hope to gain from counseling? ____________________

____

How long do you anticipate needing counseling?

☐ One-time evaluation/referral
☐ Short-term (6–8 sessions over 3–6 months)
☐ Long-term (10+ sessions over 6+ months)