DAYMARK
PASTORAL COUNSELING

Personal Profile Form

Name: _____ Sex_____ Birth Date_____

Phone: Cell_____ Work_____ Email_____

Address_____
(Include street, city and zip)

Emergency Contact: Name_____ Number_____

Referred By: _____

Daymark Pastoral Counseling sends out a quarterly newsletter that contains short articles, book reviews and news about the ministry.
_____ Yes, send me the newsletter to the email address listed above.
_____ Yes, send me the newsletter via snail mail to the address listed above.
_____ No, I would not like to receive the newsletter.

DIRECTIONS: Please answer the following questions as fully as possible.
Present Problem – "These are issues causing me stress." *Please circle all that apply*:
Relationship issues Health issues Job issues Financial issues Parent/child issues
Issues of past (guilt, abuse, neglect, family of origin issues)
Other_____

Symptoms: *Please circle all that apply*:
Change in sleep pattern Decreased concentration Change in appetite
Increased anxiety Decreased energy Decreased motivation

Circle any losses you have experienced:
Family Health Disruption of lifestyle Job Significant other
Other_____

Suicidal/Homicidal Ideation
Have you attempted to commit suicide or homicide in the past? (circle: Yes or No)
If yes, how? _____
Is there a history of suicide in your nuclear and/or extended family? (circle: Yes or No)
Have you ever inflicted burns or wounds on yourself? (circle: Yes or No)
Are you presently suicidal/homicidal? (circle: Yes or No)

What event(s) in the recent past has/have prompted you to seek counseling? _____
_____

_____
_____

How do you expect counseling to help your present situation (what are your goals)?_____
____
_____
_____
_____

Would it be beneficial for any members of your family to be involved in your counseling? (Circle: Yes or No) If yes please explain: _____
_____
_____

List your strengths and weaknesses:

Strengths	Weaknesses
_____	_____
_____	_____
_____	_____

Living Arrangements

Satisfactory Unsatisfactory How long there and with whom are you living:

_____
_____

Support System

Who can you count on for support? Circle as many as apply.

Parents Spouse Siblings Employer Church Pastor Therapist Neighbor(s) Close friend Extended family Small/Support Group Community Services Co-Worker Medical Doctor Other:_____

Please list any past difficulties in the area of religious or ethnic/cultural background:
_____
_____

Do you currently attend church? (circle: Yes or No) If yes, where? _____

Relationship Status:

(circle one): single married cohabitating divorced
If married, cohabitating or divorced on what date did this take place _____
If applicable name & age of spouse/partner: _____

What is your perception of your current relationship status (e.g. content, communicating poorly, thriving, struggling, etc.):

Have you ever been to counseling prior to today to deal with issues related to your relationship status noted

above? (circle: Yes or No) If so, what was the outcome of that counseling?
_____
_____
_____

Regarding the relationship status noted above, have you or your partner struck, physically restrained, used violence against or injured the other person within the last three years? (circle: Yes or No)

Regarding the relationship status noted above, would you describe the frequency of sex as rarely/semi-regularly/regularly/often/very often? (Circle One)

Do you sense your spouse/partner is pleased with the frequency and mutuality of your sexual relationship in your marriage? (Circle: Yes or No) Please describe_____
_____
_____

Are you sexually attracted to (please circle any that apply): men women both
Is there anything else you want us to know about you in regard to your gender or sexual orientation?"
_____
_____
_____

Family of Origin

Who could you rely on for comfort and care growing up in your home? (Circle all that apply): Mother Father Sibling Friend Other: _____ Unsure No one

List the members of your family of origin and how you got along with each one.

Family Member Comment

_____
_____
_____
_____
_____
_____
_____
_____

What was your birth order? ___of ___ children. Who primarily raised you? _____
_____
Where did you grow up? _____
_____

How would you describe your childhood? Wonderful Positive Traumatic Painful Uneventful
What were you like as a child (include friends, school, hobbies, and personality)?_____
_____
_____
_____
_____
____

Describe any significant family history of substance abuse:
_____
_____

Were there any unusual or traumatic experiences for you as a child?
Date Age Event
_____
_____

How do you think these events impacted you? _____
_____
_____

List Names and Ages of Your Children. How do you get along with each one? Problems?
Name Age Comment
_____
_____
_____
_____
_____
_____

Work Adjustment History
Place of Employment_____Position_____

What do you like/dislike about your current employment/career? Please List
Like Dislike
_____
_____
_____

Do you plan on staying at this job? _____ How many jobs have you held within the previous five years? _____ If you could choose any job what would it be? _____

Describe your relationship with your superiors and co-workers? _____
_____
_____

Describe your job performance: _____
_____
_____

Have you ever been fired? (circle: Yes or No) If yes, please explain: _____
_____
_____

Educational History
What was school like for you?_____
_____

Highest level achieved_____ What types of grades did you get? _____ Currently in school? (circle: Yes or No) If yes, what level? _____

Mental Health History
Have you experienced any mental health issues noted below (Circle any that apply and please note if it is a current or past issue):

- Bi-polar
- Depression
- Anxiety
- Panic Attacks
- OCD
- Restrictive eating
- Bingeing
- Purging
- PTSD
- Phobias
- Sexual Addiction
- Pornography Use
- Other_____

Has any member of your family of origin or immediate extended family encountered one of more of the issues noted above? If so, please note who and the frequency and severity of the issue:
_____
_____
_____

Counseling
Please list any previous outpatient counseling experiences:
Counselor_____ Dates of treatment - from_____ to _____
Reason for counseling:_____
Counselor_____Dates of treatment - from_____ to _____
Reason for counseling: _____

Hospital Admission
Please list any previous hospitalizations for mental health or addiction issues:
Place of treatment_____ Dates of treatment - from_____ to _____
Reason for treatment:_____
Place of treatment_____ Dates of treatment - from_____to _____
Reason for treatment:_____

Medication
List all medications you have taken in the past for anxiety, depression, and/or sleep:
_____

_____

Medical Information

Please describe your current condition of health:_____

Are you currently on any medication? (Circle: Yes or No) Please include the name of the medication and the prescribing physician_____

_____

Has it been more than a year since your last physical including blood tests? (Circle: Yes or No)
Do you have any allergies? (Circle: Yes or No)
If yes, explain_____

List any previous health problems, operative procedures, and medical hospitalizations:

Problem	Dates	Treatment

_____
_____
_____

Lifestyle Factors

1. What are your thoughts and beliefs about faith? Are you presently cultivating a relationship with God, and if so, how do you cultivate that relationship? _____

_____
_____
_____

2. Do you lead a physically active life in a way that supports your mental health? If so, in what ways do you regularly move your body that contributes to your mental health?
   _____
   _____
   _____

3. How would you describe your quality of sleep? (if there are areas of concern please note that)_____
   _____
   _____

4. Is there any substance or activity that you are potentially dependent on or addicted to? Or were in the past? (e.g. alcohol, pornography, caffeine, marijuana, tobacco, shopping, working out, gambling, etc.) If, so please list and describe your current usage or usage in the past.
   _____
   _____
   _____
   _____
   _____

5. Have you experienced a recent increase in the use of alcohol/other substances? (Circle: Yes or No) Please describe_____
   _____

6. Do you see your current usage as a problem? (Circle: Yes or No) If yes, when did it become problematic? _____
   _____

7. Is anyone in your life concerned about your substance use? (Circle: Yes or No) Please list who and describe their level of concern_____
   _____
   _____

8. Please describe your current use of technology/social media: _____
   _____
   _____

9. Do you consider your current use of technology an issue and if so, why? (Please describe)
   _____
   _____

10. Is there anyone in your current life concerned about your use of technology (Circle: Yes or NO) If so, who and please describe their concerns_____
    _____
    _____

11. Have your eating habits changed recently? (Circle: Yes or No) If yes, please describe_____
    _____
    _____

12. Has your weight fluctuated more than +/- 10 lbs. over the previous year? (Circle: Yes or No)
13. Do you often eat out of depression, boredom, anger? (Circle: Yes or No) If yes, please describe:
    _____
    _____

Legal History (Please explain all that apply)
Charges as a minor, Charges presently, Arrests, Convictions, Parole or Probation, Bankruptcy, Civil Suits, Child Custody Problems: _____
_____
_____
_____

Military History
List branch, dates, and duties:

Miscellaneous
Are there any other things that can be helpful for us to know about you? _____
_____
_____
_____
_____

Signature **Date**