DAYMARK
PASTORAL COUNSELING

PERSONAL PROFILE FORM

Name:_____ Sex_____ Birth Date_____

Phone #'s: _____Home _____Cell _____Work

Email_____

Address_____
(Include street, city and zip)

Marital Status: S M DW Religion_____ 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*:

Marital 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 to 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?_____ 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?_____

Marriage & Family History (if Applicable):

What is your perception of your current marriage (include communication problems):_____
_____
_____
_____

When were you married? _____ Name & age of spouse:_____
Previous marriage? (circle: Yes or No) If yes, date of divorce:_____ Any Children from that marriage:_____

Have you ever been to counseling as a result of the problems with this relationship prior to today? (circle: Yes or No) If so, what was the outcome of that counseling? _____

Have either of you or your partner struck, physically restrained, used violence against or injured the other person within the last three years? (circle: Yes or No)

What has been the frequency of sexual relations the last month _____times or Year? _____times
Are the numbers above a reflection of a change in the history of your sexual relations? If so, please describe why your sexual intimacy has changed: _____

To what degree do the two of you share similar values in regards to gender roles?
Extremely high very high high moderate low very low extremely

To what degree do the two of you share similar values in regards to religion?
Extremely high very high high moderate low very low extremely

To what degree do the two of you share similar values in regards to finances?
Extremely high very high high moderate low very low extremely

To what degree do the two of you share similar values in regards to divorce?
Extremely high very high high moderate low very low extremely

What is your current level of marital stress? (Circle one)
Extremely high very high high moderate low very low extremely low

To what degree do you have family or friends that support you as a couple? (Circle one)
Extremely high very high high moderate low very low extremely

List names and ages of you children. How do you get along with each one? Problems?
Name Age Comment

Developmental History

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? _____

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

Were there any unusual or traumatic experiences for you as a child?

Date	Age	Event

_____
_____

What is your sexual orientation? Heterosexual Homosexual Bisexual

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 make? _____

Currently in school? (circle: Yes or No) If yes, what level?_____

Treatment History

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: _____

Please list any admissions to the hospital 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:_____

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

Substance Abuse/Addiction History

Is there a substance or activity that you are potentially dependent on? Describe your current usage or usage in the past of this substance or activity (including alcohol, tobacco, shopping, working out, gambling, etc).

_____
_____
_____
_____
_____

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

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

Describe any significant family history of substance abuse:

Nutrition

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

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

If you use laxatives, water pills (diuretics), or diet medications, how often do you use them?

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**