

Interfaith Counseling Center, Inc.  
Lexington, Kentucky  
**PERSONAL INFORMATION SUMMARY FORM**  
**(Adult)**

The information asked for below is to help us understand you, your situation and to enable us to be of help to you. Please fill out this form as completely as you can.

**All information will be held in confidence.**

Date: \_\_\_\_\_

File # \_\_\_\_\_  
*(For office use)*

**Personal Information:**

Name \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address \_\_\_\_\_ Business Phone: \_\_\_\_\_

City \_\_\_\_\_ Cellular Phone: \_\_\_\_\_

State & zip \_\_\_\_\_ May we leave messages? \_\_\_\_\_

Email address: \_\_\_\_\_ May we contact you by email? \_\_\_\_\_

What is your gender? \_\_\_\_\_ Age? \_\_\_\_\_ Birth date? \_\_\_\_\_

Marital status: \_\_\_\_\_ Date of marriage(s) \_\_\_\_\_  
*(Please list all)*

Death of spouse: \_\_\_\_\_ Divorce(s) \_\_\_\_\_  
*(Date) (Date)*

**Present Household** *(names and ages)*

**Children** *(names and ages)*

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Education**

Highest educational grade completed \_\_\_\_\_ Diploma or degree: \_\_\_\_\_

**Military**

Have you served in the military? \_\_\_\_\_ Combat duty? \_\_\_\_\_ Dates: \_\_\_\_\_

**Employment**

Where do you work? \_\_\_\_\_ How long? \_\_\_\_\_

What is your job there? \_\_\_\_\_ Gross household income: \_\_\_\_\_

**Religious Information**

Did you attend church in childhood? \_\_\_\_\_ If so, which church? \_\_\_\_\_

Do you attend now? \_\_\_\_\_ Where? \_\_\_\_\_

**Referral Information**

How did you learn about the Interfaith Counseling Center? \_\_\_\_\_

If referred, by whom? \_\_\_\_\_ Title/relationship \_\_\_\_\_

Have you had previous counseling or psychotherapy? \_\_\_\_\_ Dates? \_\_\_\_\_

Are you presently seeing another therapist? \_\_\_\_\_ Who? \_\_\_\_\_

**Medical Information**

Current Weight \_\_\_\_\_ Weight 6 months ago \_\_\_\_\_ Height \_\_\_\_\_

Dieting?\_\_\_\_\_ Which plan? \_\_\_\_\_

Medical conditions you are aware of: \_\_\_\_\_

Medications you are presently taking:

\_\_\_\_\_  
(Medication) (Dosage) (Date started) (Name of doctor)

\_\_\_\_\_  
(Medication) (Dosage) (Date started) (Name of doctor)

\_\_\_\_\_  
(Medication) (Dosage) (Date started) (Name of doctor)

Last physical examination \_\_\_\_\_  
(Date) (Name of doctor)

Current Physician \_\_\_\_\_

Have you been hospitalized during the last 5 years? \_\_\_\_\_ Dates? \_\_\_\_\_

Hospital? \_\_\_\_\_ For what reason(s)? \_\_\_\_\_

Do you use alcohol? \_\_\_\_\_ How often? \_\_\_\_\_ How long? \_\_\_\_\_

Drugs? \_\_\_\_\_ How often? \_\_\_\_\_ How long? \_\_\_\_\_

I believe my present physical condition is (Circle one)

poor fair average good excellent

I believe my present emotional condition is (Circle one)

poor fair average good excellent

**Concerns:**

State in your own words the concerns you bring to counseling: \_\_\_\_\_

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**Check any items that describe or relate to the concerns mentioned above:**

- |   |   |
|---|---|
| <input type="checkbox"/> Abuse:                       | <input type="checkbox"/> Loneliness                 |
| <input type="checkbox"/> Verbal/mental                | <input type="checkbox"/> Loss                       |
| <input type="checkbox"/> Emotional                    | <input type="checkbox"/> Marriage concerns          |
| <input type="checkbox"/> Financial                    | <input type="checkbox"/> Nervousness                |
| <input type="checkbox"/> Physical                     | <input type="checkbox"/> Obsessive thoughts         |
| <input type="checkbox"/> Sexual                       | <input type="checkbox"/> Pornography                |
| <input type="checkbox"/> Other _____                  | <input type="checkbox"/> Purpose of meaning in life |
| <input type="checkbox"/> Alcohol                      | <input type="checkbox"/> Relationships:             |
| <input type="checkbox"/> Anger                        | <input type="checkbox"/> Parents                    |
| <input type="checkbox"/> Anxiety                      | <input type="checkbox"/> Siblings                   |
| <input type="checkbox"/> Compulsive behaviors         | <input type="checkbox"/> Children                   |
| <input type="checkbox"/> Depression                   | <input type="checkbox"/> Co-workers/ friends        |
| <input type="checkbox"/> Drugs                        | <input type="checkbox"/> Other _____                |
| <input type="checkbox"/> Fear                         | <input type="checkbox"/> Religious concerns         |
| <input type="checkbox"/> Financial concerns           | <input type="checkbox"/> Self-doubt                 |
| <input type="checkbox"/> Forgiveness                  | <input type="checkbox"/> Self-harm                  |
| <input type="checkbox"/> Grief                        | <input type="checkbox"/> Self-respect               |
| <input type="checkbox"/> Guilt                        | <input type="checkbox"/> Sexual concerns            |
| <input type="checkbox"/> Homosexuality                | <input type="checkbox"/> Suicidal thoughts          |
| <input type="checkbox"/> Infidelity                   | <input type="checkbox"/> Troublesome dreams         |
| <input type="checkbox"/> Insecurity                   | <input type="checkbox"/> Vocational concerns        |
| <input type="checkbox"/> Legal issues                 |   |
| <input type="checkbox"/> Other not listed above _____ |   |
| _____   |   |
| _____   |   |

Signature: \_\_\_\_\_ (Date)