

# Interfaith Counseling Center

240 Rodes Avenue  
Lexington, Kentucky 40508  
(859) 258-2060

## PERSONAL INFORMATION SUMMARY FORM

(Youth 12 – 17)

### Confidential

The information asked for below helps us understand you and your situation and enables the therapist to become better acquainted with you quickly. Please fill out this form as completely as you can.

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

File # \_\_\_\_\_

*(For Office Use)*

### Personal Information:

Name: \_\_\_\_\_

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

Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

City: \_\_\_\_\_

Email address: \_\_\_\_\_

State & Zip: \_\_\_\_\_

May we leave messages? \_\_\_\_\_

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

Birthdate: \_\_\_\_\_

Social Security # \_\_\_\_\_

### Present Household:

#### Parents (names and ages)

#### Siblings (names and Ages)

Father: \_\_\_\_\_

\_\_\_\_\_

Mother: \_\_\_\_\_

\_\_\_\_\_

Stepmother: \_\_\_\_\_

\_\_\_\_\_

Stepfather: \_\_\_\_\_

\_\_\_\_\_

Gross Family Income \_\_\_\_\_

**Education:**

Grade: \_\_\_\_\_ School name: \_\_\_\_\_

If High School, subject focus: \_\_\_\_\_ College prep \_\_\_\_\_ General \_\_\_\_\_ Vocational \_\_\_\_\_

**Employment: (If you have done any part-time work)**

Where do you work?  
\_\_\_\_\_

What is your job there? \_\_\_\_\_ How long? \_\_\_\_\_

If less than 6 months, previous place of work?  
\_\_\_\_\_

What was your job there? \_\_\_\_\_ How long? \_\_\_\_\_

**Religious Information:**

Do you attend Church or Sunday School: \_\_\_\_\_Yes \_\_\_\_\_No

If so, which church? \_\_\_\_\_

If not, have you attended in the past? \_\_\_\_\_Yes \_\_\_\_\_No

Which church? \_\_\_\_\_

**Referral Information:**

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

If referred, by whom? \_\_\_\_\_ Title/Relationship: \_\_\_\_\_

May I contact them to thank them for the referral? \_\_\_\_\_Yes \_\_\_\_\_No

Have you had previous counseling or psychotherapy? \_\_\_\_\_Yes \_\_\_\_\_No

When? \_\_\_\_\_ With whom? \_\_\_\_\_

Are you presently seeing another therapist? \_\_\_\_\_Yes \_\_\_\_\_No

**Medical Information:**

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

Dieting? \_\_\_\_Yes \_\_\_\_ No Which plan? \_\_\_\_\_

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

Are you presently taking medications? \_\_\_\_Yes \_\_\_\_No If so,

\_\_\_\_\_  
(Name) (Dosage) (Date started) (For what condition) (M.D.)

\_\_\_\_\_  
(Name) (Dosage) (Date started) (For what condition) (M.D.)

\_\_\_\_\_  
(Name) (Dosage) (Date started) (For what condition) (M.D.)

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

Current physician: \_\_\_\_\_

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

Hospital \_\_\_\_\_ For what reason? \_\_\_\_\_

Do you use drugs? \_\_\_\_Yes \_\_\_\_No Alcohol? \_\_\_\_Yes \_\_\_\_No

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

Presently I believe my physical condition is (Circle what is appropriate.)

Poor fair average good excellent

Presently I believe my emotional condition is (Circle what is appropriate.)

Poor fair average good excellent

**Concerns:**

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

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

- |  |   |
|--|---|
| <input type="checkbox"/> grief                         | <input type="checkbox"/> loneliness                     |
| <input type="checkbox"/> depression                    | <input type="checkbox"/> despair                        |
| <input type="checkbox"/> anxiety                       | <input type="checkbox"/> guilt                          |
| <input type="checkbox"/> nervousness                   | <input type="checkbox"/> vocational direction           |
| <input type="checkbox"/> fear                          | <input type="checkbox"/> relationship with teachers     |
| <input type="checkbox"/> self-doubt                    | <input type="checkbox"/> relationship with friends      |
| <input type="checkbox"/> intense anger                 | <input type="checkbox"/> relationship with parents      |
| <input type="checkbox"/> insecurity                    | <input type="checkbox"/> relationship with siblings     |
| <input type="checkbox"/> alcohol                       | <input type="checkbox"/> relationship with opposite sex |
| <input type="checkbox"/> drugs                         | <input type="checkbox"/> sexual concerns                |
| <input type="checkbox"/> homosexuality                 | <input type="checkbox"/> loss of faith in God           |
| <input type="checkbox"/> physical abuse                | <input type="checkbox"/> loss of faith in self          |
| <input type="checkbox"/> sexual abuse                  | <input type="checkbox"/> loss of faith in others        |
| <input type="checkbox"/> troublesome dreams            | <input type="checkbox"/> loss of hope                   |
| <input type="checkbox"/> sleeplessness                 | <input type="checkbox"/> loss of meaning                |
| <input type="checkbox"/> suicidal feelings or thoughts | <input type="checkbox"/> loss of self-respect           |
| <input type="checkbox"/> anger with God                | <input type="checkbox"/> loss of love                   |
|  | <input type="checkbox"/> other _____                    |

Signature: \_\_\_\_\_