Dwell Center for Healing
Personal Information Form

Date_____

Name_____

Address_____

Email_____

Cell #_____ Do you text from this number? *Yes* *No*

Other #_____ (specify work, home, etc.)

Male/Female_____ Age_____ Date of birth_____

Ethnic background_____

Relationship status_____

[single, (re)married, dating, cohabitating, engaged, separated, divorced, widowed]

Children (names and ages)_____

_____

With whom do you live? _____

Highest level of education_____

Occupation_____

Employer_____

Referred by_____

May I express thanks to him/her for the referral? *Yes* *No*

Would you like to receive emails re: Dwell Center events and updates? *Yes* *No*

In case of an emergency, I give permission for my therapist to contact the following:

Name	Best phone number	Relationship

Describe your primary concern(s) and why you decided to seek help at this time.

_____

_____

_____

What are your goals, hopes and expectations regarding counseling?

_____

_____

_____

Have you ever received counseling before? *Yes* *No*

If yes,with whom, where, when, for what reasons? Include contact phone/address

_____

_____

_____

What was the date of your last physical exam? _____

Current and significant past illnesses, health conditions _____

_____

_____

Current medications and reason(s) for taking_____

_____

Name and phone number of primary physician _____

Have you ever been prescribed or taken any medication for any psychological problems? *Yes* *No* If yes, provide the name of the medication, dosage, & dates taken.

_____

If yes, provide the name and phone number of prescribing doctor:

_____

Have you ever been hospitalized for any mental, emotional or behavioral problems?

Yes *No* If yes, when, where and for what reasons? _____

_____

_____

Did or does anyone in your family have a mental illness or emotional problems? *Yes* *No*

If yes, who and why?_____

_____

Have you experienced problems related to any of the following?
Please mark **P** if you experienced it in the past and **C** if you are currently experiencing it. Please put a ***** next to those that are significant to you NOW.

	Difficulty concentratinq		Spiritual difficulties
	Relationship difficulties		Fidqetv and restless
	Self-hatred		Affairs/infidelitv
	Fear or panic		Loss of appetite
	Pornoqraphv		Underlvinq sadness
	Sleep problems		Loss or grief
	Up and down mood cvcles		Loss of interest in work or activities
	Compulsive thoughts or behaviors		Legal problems
	Difficulties in sexual function/ performance		Hearing or seeing things that others do not
	Thoughts of death		Indecisiveness
	Difficulties with emotions		Feeling misunderstood or judged
	Difficulty trusting the motives of others		Intrusive thoughts or impulses
	Gender/sexual identity issue		Depression /hopelessness
	Anqer, frustration or rage issues		Work problems
	Overeating/undereating &/or purging		Insecurity/poor self-imaqe
	Alcohol/Substance abuse/misuse		Distressinq fantasies
	Self-harm/cuttinq		Addictions
	Anxietv/worry		Abortion
	Guilt or shame		Traumatic events (including abuse)
	Feelings of worthlessness		Flashbacks
	Promiscuitv		Isolation

Further details about significant symptoms:_____

_____

_____

Have you ever had suicidal thoughts? *Yes* *No* Suicidal attempts? *Yes* *No*

lf yes, please describe and give date(s):_____

_____

Would you like spirituality to be part of the counseling process? *Yes* *No*

_____

_____

ls there any other information you think is important for your therapist to know?

_____

_____