Bay Life Pastoral Counseling Center

Psychosocial Questionnaire

Welcome to Bay Life Pastoral Counseling Center. Therapy requires a major investment of time and resources. Please help us begin by providing the information requested below. This form and all information herein will be kept confidential. Please answer each question as completely as you can. Feel free to add comments at any time.

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Work Phone: _____ Cell Phone: _____

Email Address: _____

Date of Birth: ____/____/____ Age: ____ Legal Guardian (if minor): _____

Marital Status: Single ___ Married ___ Separated ___ Divorced ___ Widow(er) ___

Level of Education (circle one):

Did not graduate high school GED Some College 2-year degree

4-year degree Graduate Degree Vocational/Tech Other: _____

Name of School(s): _____

Occupation: _____

Employer: _____

Therapist Name: _____ Todays Date: _____

How did you find out about Bay Life Pastoral Counseling Center and/or who referred you?

_____

What do you hope to achieve through counseling? _____

_____

_____

Permission to receive e-mail and/or text notices for appointments.

Yes: ___No:___ Email: _____ Signed: _____

Yes: ___No:___ Text#/Carrier: _____Date: _____

Bay Life Pastoral Counseling Center

Current Family

Marital History

Name of current spouse: _____ Date married: _____
Your age at time of marriage: _____ Spouse's age at time of marriage: _____

Please list all children and their relationship to you as well as anyone else living in the home.

Name: _____ Age: _____ Sex: _____ Relationship to you: _____
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Name: _____ Age: _____ Sex: _____ Relationship to you: _____
Name: _____ Age: _____ Sex: _____ Relationship to you: _____
Name: _____ Age: _____ Sex: _____ Relationship to you: _____

Describe your current marriage: _____
_____
_____
_____

Previous Marriage

Have you been married previously? If so, how many times? _____
Do you have children from previous relationships? If so, please list each child's name & age.
_____
_____

Describe previous marriages and reason for termination of marriage:
_____
_____
_____

Do you consider your home a safe place to live? Yes: _____ No: _____
Are you satisfied with your current living situation? Yes: _____ No: _____
If No, briefly describe why: _____
_____

Is there anything else that is stressful or worrisome for you concerning your current family? Use the back of this paper if necessary.
_____
_____

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Presenting Problem

What brings you to Bay Life Pastoral Counseling Center at this time?

_____

_____

_____

_____

How long have you been experiencing this problem? _____

What have you tried to solve this problem? _____

How severe would you say this problem is? (Circle one) Mild, Moderate, Severe, Unbearable

Please circle any items that are of a personal concern to you.

Stress	Anxiety	Depression
Mood Swings	Guilt	Fearfulness
Grief	Anger/Temper	Worry
Hopelessness	Suicidal Thoughts	Desire to hurt others
Marital problems	Family problems	Work problems
Legal problems	Sexual addiction	Physical abuse
Sexual abuse	Emotional abuse	Adult child of alcoholic
Use of alcohol	Use of Drugs	Other: _____

Substance Use

Drug	Age of first use	Amount used Daily/weekly	Date last used
Tobacco			
Caffeine			
Alcohol			
Marijuana			
Cocaine			
Other: _____			

Please describe any concerns you have with substance use: _____

_____

_____

_____

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Family history

Has any member of your family of origin ever had emotional or mental problems?

If yes, please describe who, what the problem was, and if they received treatment.

_____

_____

_____

_____

Has any member of your family of origin ever had a problem with alcohol or drug use?

If yes, please describe who, what the problem was, and if they received treatment.

_____

_____

_____

_____

Please describe your relationship with your Father: _____

_____

_____

Please describe your relationship with your Mother: _____

_____

_____

Please describe your parent's marital relationship: _____

_____

_____

How was discipline handled: _____

_____

_____

Please list and describe the relationship you have with your siblings:

Name: _____ Age: _____ Current Relationship: _____

Name: _____ Age: _____ Current Relationship: _____

Name: _____ Age: _____ Current Relationship: _____

Name: _____ Age: _____ Current Relationship: _____

*List other on back of this sheet

Please describe your current support system (family, friends, church, support group, etc.):

_____

_____

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Medical History

Family

Please circle any conditions that apply to your family members.

Heart Disease	Arthritis	High Blood Pressure
Asthma	Diabetes	Cancer
Seizures	Anxiety disorder	Depression
Manic Depression	Schizophrenia	Hyperactivity
Chemical Addition	Dementia	Other_____

Please describe anything you circled.

_____

_____

_____

Personal

Please circle any items of concern:

Headaches	Sleeplessness	Too much sleep
Breathing difficulty	Chest pain	Blurred vision
Fatigue	Dizziness	Difficulty Concentrating
Muscle Tension	Nausea	Constipation
Diarrhea	Vomiting	Mental illness
Recent weight loss	Recent weight gain	Sexual Dysfunction
Heart disease	Arthritis	High blood pressure
Asthma	Diabetes	Cancer
Chronic pain	Seizures	Gynecological problems
Allergies (specify)_____	Memory loss	Other_____

Have you ever been hospitalized? If yes, please describe, include the year and reason.

_____

_____

_____

Please list all medications you are currently taking: _____

_____

_____

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Spirituality

Do you believe in God or a higher power?	(circle one)	Yes	No
Do you consider religion to be an important part of your life?		Yes	No
Do you attend church?		Yes	No

How would you describe your relationship with God?

_____
_____
_____
_____
_____

Please describe your religious background:

_____
_____
_____
_____
_____

Recreational

What do you do for fun?

_____
_____
_____

How many times in the last month would you say you have had fun?

_____
_____

What interests you?

_____
_____
_____

How would you describe yourself (circle one)? Shy Outgoing In-between

How satisfied are you with the quality and amount of friendships you have? _____

_____