Pre-Counseling *Inventory*

The Counseling Center at Bay City
wisdom. care. hope.

This document will be kept confidential and helps your counseling get a good start. Skip questions that feel too personal (your counselor may ask you about them). The contact info helps if we need to reach you to change an appointment.

Name: Age: ☐ Male ☐ Female Today's date: ____/____/____

Address: City: State:

Cell phone: Email:

Occupation: Average work hours per week:

How would you describe you relationship status? (Married, single, etc.)

In a sentence, please describe why you came for counseling:

In a sentence, explain what you want accomplished through counseling:

How did you hear about our counseling?

What days and times are best to meet?

Health

Please rate your physical health: Poor – **1 2 3 4 5** – Excellent

Are you taking any prescription meds? ☐ Yes ☐ No

Have you had other counseling? ☐ Yes ☐ No

If "yes," about how long did the counseling last? _____

Was the counseling helpful? ☐ Yes ☐ No ☐ Other _____

Have you ever had visual hallucinations (visions)? ☐ Yes ☐ No Auditory hallucinations (voices)? ☐ Yes ☐ No

About how much sleep do you get nightly? _____ How well are you sleeping? ☐ Poorly ☐ Average ☐ Very well

Religious Background

What is your church denomination preference?

What church do you attend? Are you a member? ☐ Yes ☐ No

How often do you attend? ☐ Occasionally ☐ Often ☐ I rarely miss church

Church denomination as a child: Religious background of spouse:

Do you believe there is a God? ☐ Yes ☐ No ☐ Uncertain

Personality Information **Circle words that describe you in general:**

Active Ambitious Self-confident Persistent Hardworking Impatient Impulsive Moody Often-sad Fearful
Excitable Imaginative Calm Serious Easygoing Shy Good-natured Introvert Extrovert People-pleaser
Idealist Likeable-leader Quiet Hard-nosed/Tough Lazy Submissive Self-conscious Sensitive
Nurturing Workaholic Fixer of relationships Artsy Deep-thinker/reflective Visionary Type-A

Circle words that describe you right now:

Lonely Lack of motivation Eating issues Difficulty making decisions Hard to concentrate Restlessness
Excessive energy Fatigued Nervous Depressed Worried Tense Panicked Suicidal thoughts
Irritable Temper outbursts Feeling guilty Feeling worthless Loss of interest in things I used to enjoy
Feeling superior to others Racing thoughts Flooded with sexual thoughts Much physical pain

Marriage If never married, check here ☐ and skip to Family Background.

Full name of spouse: Spouse occupation:

Is your spouse willing to come for counseling? ☐ Yes ☐ No ☐ Uncertain

Have either of you filed for divorce? ☐ Yes ☐ No If yes, when? _____

Have you ever been separated? ☐ Yes ☐ No If yes, how long? _____

How well are you and your spouse getting along? Poorly – **1 2 3 4 5** – Well

What year were you married? _____ Approximate age when married: You _____ Your spouse _____

Please give brief information about previous marriages:_____

_____

What's the single biggest problem in your marriage right now?_____

_____

Children (Use the back if you need more room.)

Name	Age	Gender	From a previous marriage?
_____	_____	☐M ☐F	☐ Yes ☐ No
_____	_____	☐M ☐F	☐ Yes ☐ No
_____	_____	☐M ☐F	☐ Yes ☐ No
_____	_____	☐M ☐F	☐ Yes ☐ No

Family Background/History

Is your father alive? ☐ Yes ☐ No Is your mother alive? ☐ Yes ☐ No

Religious affiliation: Father _____ Mother _____

Occupation: Father _____ Mother _____

Rate parents' marriage: ☐ Unhappy ☐ Average ☐ Happy ☐ Very Happy
Rate your childhood: ☐ Unhappy ☐ Average ☐ Happy ☐ Very Happy
How many older brothers do you have:_____ Older sisters:_____ Younger brothers:_____ Younger sisters:_____

Have there been any deaths in your family in recent years? ☐Yes ☐No If yes, who?_____

Has anyone in your family experienced depression or mental illness? ☐Yes ☐No If yes, who?_____

Have you, or anyone in your family, attempted suicide? ☐Yes ☐No If yes, who?_____

Have you had, or were part of (men), an unplanned pregnancy? ☐Yes ☐No If yes, when?_____

Have you had an abortion, or been a part of a woman's choice to have one? ☐Yes ☐No If yes, approximate year?_____

Were there any significant events happening in your life when the problem(s) began? If yes, please explain:

Have you experienced any trauma in your life? If yes, please explain: (Use the back if you need more room.)

I consent that this Inventory may be shared with the Director of Counseling and any supervisors or counselors that are involved in my counseling. I understand that my counselor may anonymously consult with other counselors in the center.

Signature _____ Date _____/_____/_____