Instep Ministries Counseling Application
Emmanuel Baptist Church

PERSONAL INFORMATION

Name _____ Birth Date _____

Address _____

Age _____Sex ____ Referred by _____

Marital Status: Single _____ Dating_____ Engaged _____ Married ____ Separated _____

Divorced _____ Widowed _____

Education: (last yr. completed) _____

Primary phone _____ Secondary phone _____

Email _____

Best modes of contact (check all that apply)? Call_____ Text_____ Email_____

Prefer to cousel in person or virtually? In person _____ Virtually _____

Employer _____ Position _____ Yrs. _____

MARRIAGE AND FAMILY

Significant Other _____ Birth Date _____ Age _____

Occupation _____ How Long Employed? _____

Home phone _____ Business phone _____

Email _____

Date of marriage _____ Length of dating _____

Give a brief statement of circumstances of meeting and dating _____
_____
Have either of you been previously married? _____

Information about children:

Name Age Sex Living Yr. Ed. Step-child

Are your children:
Homeschooled ( ) Enrolled in a private school ( ) Enrolled in public school ( )

Describe relationship with your father _____
_____
_____
Describe relationship with your mother_____
_____
_____
Provide a list of your siblings and where you are in the order _____
_____

Did you live with anyone other than parents? If so, who and for how long?
_____

Are your parents living? _____ Do they live locally?_____

HEALTH

Describe your health _____

Do you have any chronic conditions? _____ What? _____

List important illnesses and injuries or handicaps _____

Date of last medical exam _____ Report _____

Physician's name and address _____

Current medication(s) and dosage _____

Have you ever used drugs for other than medical purposes? _____

If yes, please explain _____

Do you drink alcoholic beverages? _____ If so, how frequently and how much? _____

Do you drink coffee? _____ How much? _____

Other caffeine drinks? _____ How much? _____

Do you smoke? _____ What? _____ Frequency? _____

Have you ever had interpersonal problems on the job?_____

Have you ever seen a psychiatrist or counselor?_____

Have you ever had a severe emotional upset? _____ If yes, explain _____

_____

Are you willing to sign a release of information form so that your counselor may write for social, psychiatric, or other medical records? _____

SPIRITUAL

Denominational preference _____

Church attending _____ Member _____

Church attendance per month (circle one) 0 1 2 3 4 5 6 7 8+

Do you believe in God? _____ Do you pray? _____ Would you say you are a Christian? _____, or still in the process of becoming a Christian_____

How often do you read the Bible? _____ Never _____ Occasionally _____ Often _____ Daily.

Explain any recent changes in your religious life _____
_____

Is your spouse willing to come to counseling? _____

Is he/she in favor of your coming? _____ If no, explain _____
_____

Women only: Have you had any menstrual difficulties? _____ Do you experience tension, tendency to cry, or other symptoms prior to your cycle; please explain?_____
_____

BRIEFLY ANSWER THE FOLLOWING QUESTIONS (use reverse side, if necessary)

1. What is your problem (what brings you here)?

2. What have you done about this problem?

3. What are your expectations from counseling?

4. Is there any other information we should know?

CIRCLE any of the following words which best describe you now: active ambitious self-confident persistent nervous hardworking impatient impulsive moody kindly often-blue excitable imaginative calm serious easy-going shy good-natured introvert extrovert likeable leader quiet hard-boiled submissive spiritual self-conscious lonely sensitive other _____.

Have you ever felt people were watching you?	Yes _____ No _____
Do people's faces ever seem distorted?	Yes _____ No _____
Do you ever have difficulty distinguishing faces?	Yes _____ No _____
Do colors ever seem too bright?	Yes _____ No _____
Are you sometimes unable to judge distance?	Yes _____ No _____
Have you ever had hallucinations?	Yes _____ No _____
Are you afraid of being in a car?	Yes _____ No _____
Is your hearing exceptionally good?	Yes _____ No _____
Do you have problems sleeping?	Yes _____ No _____

PROBLEM CHECK LIST

_____ Anger	_____ Envy	_____ Appetite
_____ Anxiety	_____ Fear	_____ Memory
_____ Apathy	_____ Gluttony	_____ Moodiness
_____ Bitterness	_____ Guilt	_____ Rebellion
_____ Change in lifestyle	_____ Health	_____ Sex
_____ Children	_____ Homosexuality	_____ Sleep
_____ Depression	_____ Impotence	_____ Domestic abuse
_____ Deception	_____ In-laws	_____ A vice