The Center for Family Wellness

Rev. Irvin J. Banta, BS, M. Div., D. Min., A.A.C.C.

Welcome to our office. Please complete all of the following questions.

Christian Counseling Personal Profile Form

General Information

Date: ______________________________

Name: ____ Date of Birth: ________________________

Referred By: ____________________________________ Relationship:_________________________

Type of Counseling: □ Family □ Self □ Couple

Address: ____

City: ____________________________ State: ____________________ Zip: __________________

Home Phone: _________________ Work Phone: ____________________ Cell Phone: ________________

Email Address: ___________________________ Sex: □ Male □ Female

Fees

I understand that I am personally responsible for the fees stated below. This office does not accept assignment from insurance companies for counseling services.

Signature: _________________________________ Date: ______________________

Counseling

Initial Consult Individual	Two Hours	$150.00
Individual Consult	One Hour	$75.00
Initial Consult Couple	Three Hours	$225.00
Couple Consult	One Hour	$100.00

Testing/ Report of Findings

Instruments per (MBTI, TJTA)	$75.00
Stress Bio-Feedback	$50.00
Report of Findings per Instrument/Bio-Feedback	$75.00

Cancelation Policy

Your appointment time is reserved for you. In order to cancel without charge, 24-hour notice is required. Cancellations for Monday appointments should be left on the Center's voicemail at least 24 hours in advance. Appointments cancelled for reasons other than emergency or illness will be charged the agreed fee.

Signature: ____________________________ Date: ______________________

Confidential Personal Data Inventory

Please complete this inventory carefully

Personal Identification

Name: ___________________________________ Date of Birth: _____________________________

Age: ______________ Sex: □ Male □ Female

Marital Status: □ Single □ Engaged □ Married □ Separated □ Divorced □ Widowed

Education (last year completed): ____

Employer: ________________________________ Position: ________________ Years: _____________

Marriage and Family

Spouse: _________________________________ Date of Birth: _____________________________

Age: ___________ Occupation: ____________________ How Long Employed: _______________

Date of Marriage: _______________________ Length of Dating: _________________________

Give a brief statement of circumstances of meeting and dating: ______________________________

____

____

Have either of you been previously married: □ Yes □No Who: _______________________________

Children

Name Age Sex Living Yr. Ed. Stepchild

____

____

____

Describe relationship to your father: ____

____

Describe relationship to your mother: ____

____

Number of siblings: _________________________ Your Sibling Order: _________________________

Did you live with anyone other than parents: ____

Are your parents living: ____________________________ Do they live locally: ___________________

Physical Health

Describe your health: ____

Do you have any chronic conditions: □ Yes □ No If yes, what are they: _________________________

____

List important illnesses and injuries or handicaps: ____

Date of last medical exam: _________________________ Report: _________________________________

Physician's name and address: ____

Current medications and dosage: ____

____

Have you ever used drugs for other than medical purposes: □ Yes □ No If yes, please explain: _________

____

Do you drink alcoholic beverages: □ Yes □ No If yes, how frequently and how much: ________________

Do you drink coffee: □ Yes □ No If yes, how much: ____

Do you smoke: □ Yes □ No If yes, what and frequency: _______________________________________

Have you ever had interpersonal problems on the job: ____

____

Have you ever had a severe emotional upset: □ Yes □No If yes, please explain: _____________________

____

Have you ever seen a psychiatrist or counselor: □ Yes □ No If yes, please explain: __________________

____

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

This Section for Women Only

Have you had any menstrual difficulty: □ Yes □ No

Do you experience tension, tendency to cry or other symptoms prior to your cycle: □ Yes □ No

If yes, please explain: ____

____

Is your husband willing to come for counseling: ____

Is he in favor of you coming: □ Yes □ No If no, please explain: __________________________________

____

Spiritual Health

Denominational/Religious preference: ____

Church Home: ________________________________ Are you a Member: □ Yes □ No

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

Do you believe in God: □ Yes □ No Do you pray: □ Yes □ No

Would you say you are a Christian: □ Yes □ No or still in the process of becoming a Christian: □Yes □ No

How often do you read the Bible: Never Occasionally Often Daily

Explain any recent changes in your religious life: ____

____

Emotional Health

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 (please circle those which apply to you)

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

Briefly Answer The Following Questions: (use reverse side, if necessary)

1. Have you or any member of your family ever been involved in or experienced any type of spiritual phenomenon? (i.e. angels, ghosts, magic, Ouija board, hypnotism, voodoo, transcendental meditation, out-of-body experience, speaking to or hearing from the dead, spells, visions, etc.) ___________
   ____
   ____
   ____

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

3. What have you done about this problem?
   ____
   ____
   ____
   ____

4. What are your expectations from counseling?
   ____
   ____
   ____
   ____

5. Is there any other information we should know?
   ____
   ____
   ____
   ____