

Counselling Application

This form gives us an overview of your story so we can understand how best to serve you. Please take the time to fill it out honestly and thoughtfully. We will handle your information with appropriate discretion. If there is a question that you feel uncomfortable answering, you can leave it blank and discuss it with your counsellor. Please note that sufficient information is required for us to properly triage your case, so any form that is inadequately filled out may be returned to the applicant to be appropriately completed.

Personal & Contact Information

Name:		
Phone:	Email:	
Address:		
Occupation:	Employer:	
Birth Date:	Age:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Engaged <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Remarried <input type="checkbox"/> Widow		
Education (last level completed/degree):		
Other Training:		
Previous Job:		
How did you hear about us?		
Emergency Contact:	Emergency Contact #:	

Marriage & Family

Spouse's Name:	Occupation:
Phone:	Age:
Religion:	Education:
How long have you been married to your current spouse?	
How long did you know your current spouse before marriage?	
Does your spouse know you are coming for counselling? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is your spouse willing to come to counselling? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain	
Have you ever been separated from your current spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, from when to when?	
Have you been previously married? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Give brief information about any previous marriage(s) for yourself or your spouse:	

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List information about any children: Name / Age / Gender / Education / Stepchild? / Deceased (when?)

Describe your relationship with your father:

Describe your relationship with your mother:

If you were raised by anyone other than your own parents, briefly explain:

List information about any siblings: Name / Age / Gender / Deceased (when?)

Upbringing

Describe your home life during your childhood and teen years:

Did you experience any of the following as a child or teen:

- Family problems
- School problems
- Emotional/behavioural problems
- Legal problems
- Medical problems
- Disordered eating
- Drug/alcohol problems
- Physical/sexual abuse
- Suicidal thinking
- Self-harm
- Social problems
- Same-sex attraction
- Gender dysphoria

Have you or any immediate family member been hospitalized or received professional help for psychological problems? Specify person, dates, and problem:

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History & Health

Have you dealt with severe emotional struggles in your past? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever had any therapy or counselling before? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Why was counselling sought?	
What was the counsellor's diagnosis?	
What was the outcome or result of your counselling?	
Rate your health: <input type="checkbox"/> Very good <input type="checkbox"/> Good <input type="checkbox"/> Average <input type="checkbox"/> Declining <input type="checkbox"/> Other	
Approximately how many hours of sleep do you get per night?	
When do you go to sleep at night?	When do you get up?
When is the last time that you have been seen by a doctor for a physical?	
Do you have any chronic medical conditions?	
Are you presently taking prescription medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Drug(s) & Dosage:	
How often do you consume alcohol? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Very little or never	
Are you using any drug (including marijuana) recreationally? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Previously <input type="checkbox"/> Never	
Have you ever been arrested? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, what year and for what reason?	

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Current Situation

Please rate how the following words describe you now: 0 = not at all / 1 = mildly / 2 = moderately / 3 = extremely					
Angry	Anxious	Moody	Withdrawn	Distrustful	Heartbroken
Guilty	Offended	Jealous	Exhausted	Emotional	Perfectionist
Resentful	Insecure	Lonely	Hopeless	Conflicted	Uninterested
Confused	Impulsive	Fearful	Defeated	Manipulated	Overwhelmed
Inflexible	Shameful	Nervous	Impatient		

Standard Safety Questions

<p>Have you recently had any serious thoughts about killing yourself? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, please explain:</p>
<p>Do you feel safe at home? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, please explain:</p>

Faith Profile

Your current Church:	Since when?
Your previous Church (if any):	For how long?
<p>How many church gatherings and activities do you attend per month?</p> <p><input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 8+</p>	
<p>Do you consent for us to contact your pastor for background information? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Do you believe in God? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain</p>	
<p>Do you consider yourself "Saved"? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain</p>	
<p>Do you believe the Bible has the authority to tell you how to live? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain</p>	
<p>Do you believe the Bible provides sufficient guidance and instruction for addressing your problems?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain</p>	
<p>Briefly explain your understanding of the gospel:</p> 	

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What are you currently doing to promote your spiritual growth?

Explain any recent changes in your walk with the Lord.

How would you define sin?

What sins do you struggle with?

Briefly Answer the Following Questions to Help us Understand Your Situation Better:

1. How would you describe the issue(s) you are struggling with?

2. What have you tried to do about it?

3. How do you hope counselling might help? (What are your expectations in coming here?)

4. What brings you here currently? (Did any recent event cause you to seek counselling right now?)

5. What do you feel you need in life? Where do you find refuge, comfort, pleasure, or security?

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6. When have you struggled with bitterness or jealousy?

7. What do you fear or what do you worry about?

8. What defines success or failure for you?

9. What brings out the worst in you, or makes you angry? (What triggers you?)

10. Finish this sentence, "People who know me think that I am..."

11. Finish this sentence, "If they knew the 'real me', they would know that I am..."

12. Where have you struggled with regret, being tempted to say, "If only..."

13. Where do you believe that God has let you down?

14. What situations do you regularly seek to avoid?

15. Is there any other information you think we should know to help you?