SOUL RESTORATION PROJECT
HEAL·LOVE·TRANSFORM

Personal Information Form

www.soulrestorationproject.org

Date: _____

Name _____

Street _____

City, St/Zip _____

Email _____

Cell # _____ Do you text from this number? Yes No

Other # _____ (specify work, home, etc.)

Male/Female _____ Age_____ Date of Birth_____

Ethnic Background _____

Relationship status _____
(single, dating, cohabitating, engaged, married, separated, divorced, widowed)

Children (names and ages)

_____

_____

With whom do you live? _____

Highest level of education _____

Occupation _____

Employer _____

Referred by _____

May I express thanks to him/her for the referral? _____

Would you like to receive email updates re: SRP events and updates? Yes No

Describe your primary concern(s) and why you decided to seek help at this time.

_____

_____

_____

What are your goals, hopes and expectations regarding psychotherapy?

_____

_____

_____

Have you ever received counseling before? Yes_____ No_____
If yes, please describe.

_____

_____

What was the date of your last physical exam? _____

Current or significant past illnesses, health conditions: _____

_____

_____

Current medications and reason(s) for taking:_____

_____

_____

Have you ever been prescribed or taken any medication for any mental, emotional or behavioral problems? Yes _____ No _____
If yes, please describe.

_____

_____

Have you ever been hospitalized for any mental, emotional or behavioral problems?

Yes _____ No _____ If yes, please describe.

_____

_____

Did or does anyone in your family have a mental illness or emotional problems?
Yes_____ No_____ If yes, please describe.

_____

_____

_____

Have you experienced any of the following? Please mark P if you experienced it in the past and C if you are currently experiencing it. Please put a * next to those that are significant to you NOW. Please give any further details in the space on the following page.

	Difficulty concentrating		Purging after eating		Relationship difficulties
	Fidgety and restless		Loss of appetite		Affairs/infidelity
	Fear or panic		Excessive exercise		Pornography
	Self-hatred		Poor body image		Problematic sexual thoughts/behaviors
	Underlying sadness		Sleep problems		Problems related to gender or sexual identity
	Up and down mood cycles		Loss of interest in work or activities		Difficulties in sexual function/performance
	Excessive worry		Social isolation/withdraw		Compulsive behaviors
	Difficulty trusting the motives of others		Intrusive thoughts or impulses		Hearing or seeing things others do not
	Depression		Intrusive memories		Alcohol abuse/misuse
	Anxiety		Anger and hostility		Substance abuse/misuse
	Overeating		Insecurity		Addictions
	Under-eating		Self-harm/cutting		Distressing or violent fantasies

Further comments:

_____

_____

Have you ever had suicidal thoughts? Yes No Attempts? Yes No
If yes, please describe and give date(s).

_____

_____

Would you like spirituality to be part of the counseling process? Yes / No
If yes, please describe your spirituality.

_____

_____

_____

Is there any other information you think is important for your therapist to know?

_____

_____

_____