



DR BRIAN HOOPER M.Div., M.S., Psy.D.

Integrative Pastoral Counselor & Certified Clinical Hypnotherapist



**Confidential
Counselee Information Form**

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Certified Pastoral Counselor**

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Counselee Information Form

Today's Date: _____

Personal and Family Information

Client's Name: _____

Age: _____ Birth Date: _____

Address: _____
(Street) (City) (State) (ZIP)

Home # _____ Cell # _____ Work# _____

At which phone number may a message be left? _____

Self-Perception of Sexual Orientation: Circle the (*) on the scale below that best represents where you see yourself to be on a scale from Heterosexual (Straight) to Homosexual (Gay).

* * * * *
Straight ----- Gay

Other: _____

Religion (if any) _____ Do you practice?
___ Yes ___ No

Education: _____ Occupation: _____

Current Marital/Relationship Status:

___ Single
___ Engaged How long? _____
___ Married/Partnered How long? _____ Times married/partnered? _____
___ Divorced/Separated How long? _____

Spouse's or Significant Other's Name _____ Age: _____

Children

List the names of those living with you.

Name	Current Age	Sex	Father's/Mother's Name
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(If necessary, continue on back of page or attach an additional sheet.)

Co-Residents (Spouse, roommates, children, etc.)

List the names of those living with you.

Name	Current Age	Sex	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(If necessary, continue on back of page or attach an additional sheet.)

Prior Counseling

Have you had any prior counseling?

___ Yes ___ No If yes, when? _____ Where? _____

With whom? _____

Why? _____

From: _____ to _____

What was most beneficial about your counseling experience? _____

Are you, or another family member, currently seeing a psychiatrist or another counselor?

___ Yes ___ No

If so, who is in therapy? _____

Presenting Concerns

State the problem that brings you for counseling: _____

(If necessary, continue on back of page or attach an additional sheet.)

What have you done about this problem? _____

(If necessary, continue on back of page or attach an additional sheet.)

What is your most difficult relationship right now? _____

What is your most difficult emotion right now? _____

Common Problems/Symptom Checklist

Fill in: 0 = none, 1 = mild, 2 = moderate, 3 = severe

- | | | |
|---|---|--|
| <input type="checkbox"/> marriage/partnership | <input type="checkbox"/> disabled | <input type="checkbox"/> loneliness |
| <input type="checkbox"/> premarital | <input type="checkbox"/> work/career | <input type="checkbox"/> mood swings |
| <input type="checkbox"/> singleness | <input type="checkbox"/> school/learning | <input type="checkbox"/> God/faith |
| <input type="checkbox"/> sexual issues | <input type="checkbox"/> money/budgeting | <input type="checkbox"/> church/ministry |
| <input type="checkbox"/> family | <input type="checkbox"/> aging/dependency | <input type="checkbox"/> past hurts |
| <input type="checkbox"/> children | <input type="checkbox"/> weight control | <input type="checkbox"/> codependency |
| <input type="checkbox"/> parents | <input type="checkbox"/> alcohol/drugs | <input type="checkbox"/> intimacy |
| <input type="checkbox"/> in-laws | <input type="checkbox"/> other addictions | <input type="checkbox"/> communication |
| <input type="checkbox"/> divorce/separation | <input type="checkbox"/> grief/loss | <input type="checkbox"/> self-esteem |
| <input type="checkbox"/> sexual orientation | <input type="checkbox"/> depression | <input type="checkbox"/> stress management |
| <input type="checkbox"/> gender identity | <input type="checkbox"/> fear/anxiety | |
| <input type="checkbox"/> child custody | <input type="checkbox"/> anger control | |

Crisis Information

Person to contact if you were involved in an emergency (name, relationship, phone, address):

Any current or suicidal thoughts, feelings or actions?

Yes No If yes, explain: _____

Any current homicidal or assaultive thoughts, feelings, or anger-control problems?

Yes No If yes, explain: _____

Any past problems, hospitalizations, or jailings for suicidal or assaultive behavior?

Yes No If yes, describe: _____

Any threats of significant loss or harm (illness, divorce, custody, job loss, etc.)?

Yes No If yes, describe: _____

Medical Information

Doctor's name, address, and phone:

Are you presently taking any medication?

Yes No If so, please list below:

	Name of Medication	Dose	For What Purpose
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

(If necessary, continue on back of page or attach an additional sheet.)

Have you recently ceased taking any medication?

Yes No If so, please list below:

	Name of Medication	Dose	Reason for Stopping
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

(If necessary, continue on back of page or attach an additional sheet.)

Do you currently drink alcohol?

Yes No If so, how much and how often? _____

Do you use/have you used any illegal substances?

Yes No If so, what, when and how much? _____

Any problems with the following:

eating sleeping
 chronic pain recent weight changes

Describe any answers checked in previous question: _____

Have you had a physical examination within the last month?

Yes No If yes, please provide the Doctor's name, address, and phone: _____

In the past year I have received medical treatment for:

1. _____
2. _____
3. _____

Any other medical problems? _____

Have you or a family member ever been hospitalized for mental or emotional illness?

Yes No If yes, please note approximate date(s), place(s), and reason(s):

Please describe your diet: _____

Do you take any dietary supplements?

Yes No If yes, please list them: _____

Please describe your sleep patterns, including amount and times:

Have you ever experienced a brain injury, blacked out, had blurred vision, concussion, felt "woozy" after a bump to your head?

Yes No If yes, please explain: _____

Who referred you to me? (name, relationship, and phone number)

If a professional referred you to me, may I acknowledge your contact? (If yes, I will only acknowledge your contact; any other information will require your express written permission.)

Yes No

Additional Notes:

THANK YOU for taking the time to fill out this information form. I will review this with you in the first session and use it to best assist you in your counseling work. I will maintain your strict confidence regarding this information, subject to the exceptions noted in your "Pastoral Counseling Agreement." Be sure you review and sign the elements of the agreement.