TIFFANY IVEY, BCCC

CONFIDENTIAL INFORMATION FORM

This form will enable us to gain a better understanding of you and it will become a part of your confidential file. Please answer each question as completely as possible. *Couples: Please fill out two forms, one for each person.*

Date: ___________________

Name _________________________________ M _____ F _____ DOB ______________ Age ___________

Address _________________________________________________________________________________

City __________________________________________ State ____________________ Zip _____________

*Please prioritize the best way to reach you (Ex. 1, 2, 3) and indicate whether we may leave a message at each number (yes or no).*

_____ Home Phone _______________________________________ Yes No

_____ Cell Phone _________________________________________ Yes No

_____ Work Phone _______________________________________ Yes No

Emergency contact name/phone number _____________________________________________________

Occupation ____________________________________ Employer __________________________________

Current Marital Status: Single ______ Married ______ Divorced _______ Separated _______

Widowed ______ How long? _________________

*If Married:*

Spouse's Name _____________________________________________ DOB _______________ Age _______

How long were you engaged? _________________________________________________________________

This is your _______ marriage. This is your spouse's _______ marriage. (Indicate 1st, 2nd, 3rd, etc.)

Name and ages of any children: ______________________________________________ Age ____________

______________________________________________ Age ____________

______________________________________________ Age ____________

Where do you attend church? ______________________________________________________________

Are you a member/regular attender there? Yes No

**PRESENTING PROBLEMS**

Please tell us, in your own words, the problems you are experiencing:

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Please tell us what you would like to change or work on in counseling:

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

How long has this been a significant issue for you? Please be specific (i.e. not "all my life").

_____________________________________________________________________________________

Have you experienced any significant loss/crisis/life change recently? Please explain.

_____________________________________________________________________________________

_____________________________________________________________________________________

Please indicate any of the following problems/symptoms that you are currently experiencing:

___ Anxiousness
___ Loneliness
___ Restlessness
___ Depression
___ Despair
___ Grief
___ Financial Issues
___ Parenting Issues
___ Eating Disorder

___ Anger
___ Guilt/Shame
___ Abuse
___ Confusion
___ Fear
___ Hurt
___ Marital Issues
___ Social Withdrawal
___ Infidelity

___ Fatigue/Loss of energy
___ Alcohol/Drug Dependency
___ Cutting/Self-Injury
___ History of Sexual Abuse
___ Suicidal Thoughts
___ Spiritual Concerns
___ Sexual Issues
___ Unforgiveness
___ Other: _______________