Compass Consulting

Pre-Counsel Profile

Dr. Rick Petronella, Ph.D.
Clinical Director

BethanyKinzel,MA,LPC,NCC
Licensed Professional Counselor

CharityL.Simpson,MS,LAPC,NCC,MDiv
Counselor & Program Director

Lisa Petronella, RN
Counseling Intern

Date:_____ Referred by: _____

The following information will become a part of your confidential file. This will help us to clearly focus on the areas of concern that you may desire to work on in counseling. Please answer each question as completely and carefully as you can. You may use the back of any page for additional comments.

PERSONAL INFO

Name:_____ Age:_____ DOB:_____ Gender:_____

Address:_____ Email Address: _____ City:_____

_____ State:_____ County:_____ Zip: _____

Home Phone:_____ Mobile Phone: _____

Marital Status:_____ # of Children & Ages _____

EMPLOYER INFO

Employer:_____ Occupation:_____

Employer Address: _____

City:_____ State:_____ County:_____ Zip:_____

Work Phone:_____ Email Address: _____

EMERGENCY CONTACT

Name:_____ Relationship:_____

Address:_____

City:_____ State:_____ County:_____ Zip:_____

Home Phone:_____ Mobile Phone: _____

PATIENTS/CLIENTS UNDER 21 YEARS OF AGE

Parent/Guardian Name:_____ Email Address: _____

Address:_____

City:_____ State:_____ County:_____ Zip:_____

Home Phone:_____ Mobile Phone: _____

Work Phone:_____ Email Address: _____

Compass Consulting

Pre-Counsel Profile

Dr. Rick Petronella, Ph.D.
Clinical Director

BethanyKinzel,MA,LPC,NCC
Licensed Professional Counselor

CharityL.Simpson,MS,LAPC,NCC,MDiv
Counselor & Program Director

Lisa Petronella, RN
Counseling Intern

EDUCATIONAL BACKGROUND

Circle last year of school completed:
Grade School: 1 2 3 4 5 6 7 8
High School: 9 10 11 12
G.E.D: Y / N
College/Technical/Grad School: 1 2 3 4 5 6+

Name of High School: _____

High School Graduation Date _____

Name of College/University/Technical College _____

List major(s) or any degree(s)/certification(s) held? _____

MEDICAL/COUNSELING BACKGROUND

Describe any physical problems or handicaps you have that require medication or physical care:

_____

_____

Are you currently receiving medical treatment? YES ☐ NO ☐

If yes, what is the type and purpose? _____

_____

Have you used drugs for other than medical purposes? YES ☐ NO ☐

If so, what drugs and with whom? _____

_____

Have you been in counseling/therapy/mental health care before? YES ☐ NO ☐

If yes, when and for what reason? _____

Please describe the type of therapy used and your response as well as current preferences.

_____

_____

Have you ever taken medication prescribed for emotional reasons? YES ☐ NO ☐

If yes, when, what type, and for what purpose? _____

_____

Are you currently taking medication prescribed for emotional reasons? YES ☐ NO ☐

If yes, what is the medication and for what reason is it being taken? _____

_____

Compass Consulting

Pre-Counsel Profile

Dr. Rick Petronella, Ph.D.
Clinical Director

Bethany Kinzel, MA, LPC, NCC
Licensed Professional Counselor

Charity L. Simpson, MS, LAPC, NCC, MDiv
Counselor & Program Director

Lisa Petronella, RN
Counseling Intern

MARITAL BACKGROUND

Marital Status: Single ☐ Married ☐ Remarried ☐ Separated ☐ Divorced ☐ Widowed ☐

Name of Spouse/Significant Other: _____

His/Her Occupation & Employer: _____

Is your spouse/significant other willing to participate in counseling? YES ☐ NO ☐ Unsure ☐

Date of current marriage: _____ Ages when married: Husband _____ Wife _____

Have you ever been separated? YES ☐ NO ☐ If yes, when? _____

Date of previous marriage: _____ Ages when married: Husband _____ Wife _____

Date of previous marriage: _____ Ages when married: Husband _____ Wife _____

List all marriages, including the current one, in order. Please indicate the following information for each: (1) your age at the time of the marriage(s), (2) how long the marriage(s) lasted, (3) whether it was broken by death or divorce, and (4) the basic reason for the break-up of the relationship.

_____

_____

_____

_____

List and give the following information about each child you have: (1) name (2) age) (3) gender) (4) born to which marriage, (5) marital status of child (if applicable) or if he/she has left home (6) any children who have died (for children who have died, please indicate age at the time of death and cause of death).

_____

_____

_____

_____

MEDICAL/COUNSELING BACKGROUND

Your religious/spiritual/denominational _____ Active ☐ Inactive ☐

Spouse/significant other's denominational preference _____ Active ☐ Inactive ☐

Were you raised in a particular church/religion? YES ☐ NO ☐ If yes, please describe: _____

How important to you are spiritual matters? Not ☐ A Little ☐ Moderately ☐ Very ☐

Dr. Rick Petronella, Ph.D.
Clinical Director

BethanyKinzel,MA,LPC,NCC
Licensed Professional Counselor

CharityL.Simpson,MS,LAPC,NCC,MDiv
Counselor & Program Director

Lisa Petronella, RN
Counseling Intern

FAMILY BACKGROUND

Birth/Adopted Parents: Married ☐ Remarried ☐ Separated ☐ Divorced ☐

Their marriage lasted:_____years

Rate your parents' marriage: Unhappy ☐ Average ☐ Happy ☐ Very Happy ☐

If separated or divorced, how old were you at the time?_____years old

Father remarried when you were age:_____Mother remarried when you were age: _____

You lived with: Mother ☐ Father ☐ Foster Parent(s) ☐ Other Family Member ☐

How many times was your father remarried?_____Your mother? _____

What kind of relationship did you have with your parents? _____

Father deceased? YES ☐ NO ☐ If yes, how old were you at the time of his death? _____

Mother deceased? YES ☐ NO ☐ If yes, how old were you at the time of her death? _____

What kind of relationship did you have with your stepparent(s)? _____

Natural Father's occupation: _____

Natural Mother's occupation: _____

Stepfather's occupation: _____

Stepmother's occupation: _____

List your brother(s) and sister(s) (including stepbrothers and step sisters) from oldest to youngest including yourself. Please give each sibling's name and age.

Dr. Rick Petronella, Ph.D.
Clinical Director

BethanyKinzel,MA,LPC,NCC
Licensed Professional Counselor

Charity L. Simpson, MS, LAPC, NCC, MDiv
Counselor & Program Director

Lisa Petronella, RN
Counseling Intern

CONCERNS & COUNSELING GOALS

FAMILY BACKGROUND

Check the statements that best describe your family history.

- ☐ Warm relationship with father /mother
- ☐ Warm relationship with brothers/sisters
- ☐ Sibling rivalry
- ☐ Father/Mother absent physically emotionally
- ☐ Close to extended family
- ☐ Moved frequently
- ☐ Parental job loss/financial instability
- ☐ Relatives lived nearby
- ☐ Close relationship with grandparents/aunts/uncles/cousins
- ☐ Alcohol drug abuse or other compulsive behaviors by father/mother
- ☐ Addictive or compulsive behaviors in other family members
- ☐ Chronic physical, mental, or emotional illness in family members
- ☐ Rigid, perfectionist standards
- ☐ Lack of rules and boundaries
- ☐ Frequent/excessive anger and conflict
- ☐ Physical/emotional/sexual abuse by family members(s)

Dr. Rick Petronella, Ph.D.
Clinical Director

BethanyKinzel,MA,LPC,NCC
Licensed Professional Counselor

Charity L. Simpson, MS, LAPC, NCC, MDiv
Counselor & Program Director

Lisa Petronella, RN
Counseling Intern

CONCERNS & COUNSELING GOALS

In the following list, place a single check mark (✓) next to each item that is an area of concern for you. Place two (2) check marks (✓ ✓) beside those items that are of higher concern to you. Please add any comments you wish to make in the space provided next to the items

☐ ☐ Abused as a child _____

☐ ☐ Anger _____

☐ ☐ Anxiety _____

☐ ☐ Bitterness _____

☐ ☐ Career Issues _____

☐ ☐ Concerns about my physical health _____

☐ ☐ Concerns about my weight and/or eating habits _____

☐ ☐ Depression _____

☐ ☐ Difficulty Sleeping _____

☐ ☐ Educational Concerns _____

☐ ☐ Family problems _____

☐ ☐ Fear _____

☐ ☐ Financial Concerns _____

☐ ☐ Feeling depressed over a recent illness or death of family member or other person close to me

---

☐ ☐ Feeling a general lack of motivation and commitment _____

☐ ☐ Feeling sad over recent breakup with spouse or significant other _____

☐ ☐ Feeling confused about my beliefs and values _____

☐ ☐ Feeling lonely _____

☐ ☐ Having peculiar feelings or experiences that trouble me _____

☐ ☐ Knowing how to be assertive _____

☐ ☐ Worrying too much about unimportant things _____

☐ ☐ Life Transitions _____

☐ ☐ Marital problems _____

☐ ☐ Managing my time _____

☐ ☐ Problems with children _____

☐ ☐ Problems with parent(s) _____

Dr. Rick Petronella, Ph.D.
Clinical Director

BethanyKinzel,MA,LPC,NCC
Licensed Professional Counselor

Charity L. Simpson, MS, LAPC, NCC, MDiv
Counselor & Program Director

Lisa Petronella, RN
Counseling Intern

CONCERNS & COUNSELING GOALS

☐ ☐ Religious/Spiritual concerns _____

☐ ☐ Relationship Problems _____

☐ ☐ Sadness _____

☐ ☐ Suicidal thought _____

☐ ☐ Trouble making decisions _____

☐ ☐ Use of alcohol, drugs, food, or other addictive/compulsive behaviors by **self** _____

☐ ☐ Use of alcohol, drugs, food, or other addictive/compulsive behaviors by **others** _____

☐ ☐ Work _____

☐ ☐ Other Concerns _____

Please briefly describe the changes that you would like to make in your life and relationships as a result of coming to counseling:

Do you feel that your need for counseling will be:

☐ A one-time evaluation and referral

☐ Short-term (six to eight sessions over three to six months)

☐ Long-term (ten plus sessions over more than six months)

I HEREBY ATTEST THAT THE INFORMATION PROVIDED ON THESE FORMS IS TRUE TO THE BEST OF MY KNOWLEDGE.

_____ _____

SIGNATURE OF RESPONSIBILITY PARTY DATE