

801 Maplewood Dr
Suite 16
Jupiter, FL 33458
Voice: 561-575-7404

Concinnity Counseling Center **Counseling Questionnaire**

For Phone Counseling
fax completed form to:
561-575-0749

Date of Initial Consultation: _____ / _____ / _____

First Name: _____ Last Name: _____

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Fax: _____ Email Address: _____

Marital Status: ' Married ' Single ' Separated ' Divorced Number of Children: _____

If married, date of marriage: _____ If divorced, date: _____

Are you a member of a church or a Bible Study or Prayer group? ' Yes ' No

If yes, what is the church's or group's name? _____

Senior Leader's Name: _____ How often do you attend? _____

When were you Born Again? _____

Are you Spirit-Baptized with evidence of speaking in tongues? ' Yes ' No. If yes, when received? _____

Are you functioning in any form of ministry now? ' Yes ' No. If yes, what: _____

Have you received any kind of counseling before? ' Yes ' No. If yes, explain: _____

Are you presently under the care of a mental health professional? ' Yes ' No. If yes, explain: _____

Are you here alone or with someone? ' Alone ' With someone. Relationship? _____

How did you hear about our service? ' Radio/TV ' Friend/Relative ' Print Ad ' Other: _____

Reason you are seeking counseling? _____

Signature(s): _____

With your signature you are indicating that you understand and acknowledge that Concinnity Counseling Center is a Christian Ministry and that the counseling you will be receiving is Christian, pastoral counseling.