

Christian Counseling Services Client Intake Form

Name _____ DOB _____ Today's Date _____

(Minor) _____

Name of person filling out this form other than self and reason: _____

Full Address _____

Cell _____ Home _____ Email _____

OK to leave messages: Yes No If yes, where _____

Is it ok to send you an appointment reminder text or call? Yes No If yes, where _____

Employer _____ Occupation _____

Student (if so) school _____

In Case of Emergency _____ Relationship _____ Phone _____

Referred by _____ May we send them a thank you? Yes No

Problem Assessment

Present Problem - Precipitating Stressors: "In recent months, I have worried a lot about"

Please circle all that apply:

Marital issues Health issues Job issues Financial issues Parent/child issues

Issues of the past (guilt, abuse, neglect, family of origin issues, etc.)

Other _____

Symptoms: *Please circle all that apply:*

Change in sleep pattern Decreased concentration Change in appetite

Increased anxiety Decreased energy Suicidal feelings

Decreased motivation Other _____

Suicidal/Homicidal Ideation

Have you attempted to commit suicide or homicide in the past? Yes No

If yes, How? _____

Is there a history of suicide in your nuclear and/or extended family? Yes No

Have you ever inflicted burns or wounds to yourself? Yes No

Are you presently suicidal/homicidal? Yes No

What issues have brought you to seek counseling and what are you hoping to achieve through counseling? _____

When did these problems develop? _____

Circle any recent losses you have experienced.

Family Health Disruption of lifestyle Job Significant other
Other _____

List your Strengths and Weaknesses

Strengths

Weaknesses

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Living Arrangements:

Where do you currently live? _____ How long there? _____

With whom do you live? _____

Describe your current relationship with family member's _____

Support System:

Who can you count on for support? *Circle as many as apply.*

Parents Spouse Siblings Employer Church Pastor Therapist
Extended family Neighbor(s) Self-help Group Close friend Community Service Co-Worker
Medical Dr. Other _____

Financial Situation:

Describe briefly your financial situation _____

Relationship History:

When were you married? _____ Name and age of spouse/significant other _____

Previous marriage(s)? Yes No If yes, date of divorce(s) _____

Any children from this marriage/relationship(s)?

What is your perception of your current relationship status?
(Include communication patterns, problems, sexual relations) _____

List names and ages of children. How do you get along with each one?

<u>Name</u>	<u>Age</u>	<u>Comment</u>	<u>Bio, Step, Adopted</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Religious/Cultural Factors:

Please list any issues, which are important or may have affected you in regard to religion or ethnic/cultural background. _____

What is your religious background? _____

Do you attend religious services? If so, where and how frequent? _____

Nutrition:

Have your eating habits changed recently? Yes No If so, please describe _____

Has your weight fluctuated more than +/- 10 lbs. over the previous year? Yes No
Do you often eat out of depression, boredom, and anger? Yes No If yes, please describe

If you use laxatives, water pills (diuretics), or diet medications, how often do you use them? _____

Legal History:

Please explain all that apply:

Charges as a minor _____

Charges presently _____

Arrests (how many) _____

Parole/Probation _____

Convictions (how many) _____

Bankruptcy _____

Civil Suits _____

Developmental History:

List members of your family of origin and how you got along with each one.

Family member

Comment

What was your birth order? # ___ of ___ children. Who primarily raised you? _____

How would you describe your childhood? Traumatic Painful Uneventful

What were you like as a child? (Include friends, school, hobbies, and personality) _____

Were there any unusual traumatic experiences for you as a child?

Date

Age

Event

What is your sexual orientation? _____

Psychiatric History

Please list previous outpatient counseling experiences.

Place _____

Length of time there _____ Dates _____

Have you ever been admitted to a hospital for mental health of addiction issues? Yes No

Place _____

Length of time there _____ Dates _____

Name of current doctor and/or therapist _____

List all medications you have taken in the past for anxiety, depression, and/or sleep:

Medical Information:

How would you describe your current health? _____

Are you currently on any medication? Yes No

Name of medication	Dosage/frequency	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has it been more than a year since your last physical exam including blood test? Yes No

Have you ever had an abortion? Yes No

List any previous health problems, operative procedures, and medical hospitalizations:

Problem	Date	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Substance Abuse History:

Describe your current usage or usage within the past year (including alcohol, caffeine and tobacco).

<u>Substance</u>	<u>Amount</u>	<u>Frequency</u>	<u>Age of 1st use</u>	<u>Age regular use started</u>	<u>Last use</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Have you experienced a recent increase in the use of alcohol and/or other substances? Yes No
Do you see usage as a problem? Yes No If yes, when did it become problematic?

Please describe any previous experience with drugs or alcohol _____

Please describe significant family history of substance abuse _____

Work Adjustment History:

Describe your current job/career _____

What do you like/dislike about your employment/career? Please list

Like

Dislike

How do you deal with authority figures? _____

Describe your relationship with co-workers/supervisor/boss _____

Have you ever been fired? Yes No If yes, please explain _____

Military History:

Educational History:

What was school like for you? _____

Highest level achieved _____

What type of grades did you make? _____

Family:

Would it be beneficial for any members of your family to be involved in your treatment?

Yes No If yes, explain who and why _____

Additional Information:

Are there any other things that can be helpful for us to know about you? _____

Client Signature

Date
