NCChristian Counselor

INDIVIDUAL ADULT CLIENT INTAKE FORM

I am glad you have sought out help. I am here to assist the healing and growth process in your life. The success of that process will greatly depend on your active cooperation and participation.

In order to best serve you, please provide the following information. Your answers will remain confidential (**please print**)

Full name: _____ Birth date: _____

Address: _____

City: _____ Zip: _____

Cell Phone: _____ Work Phone _____

Home Phone _____ May I leave a message (circle one) Yes No

E-mail: _____ *Please be aware that email might not be confidential.

Marital Status: ☐Never Married ☐Partnered ☐Married ☐Separated ☐Divorced ☐Widowed

Spouse's name:_____ How long married?_____

Children (list names, ages, where residing):_____

_____

Have you previously sought counseling? _____

When, and for what reason: _____

Name of therapist: _____

Have you been previously or currently prescribed psychiatric medication? ☐ No ☐ Yes

What medication? _____

For what reason? _____

For what reason do you now seek help? _____

_____

HEALTH AND SOCIAL INFORMATION

How is your physical health at present?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): _____

_____

Are you currently taking prescription medication for these conditions or any others?

Yes ____ No ____ What medications? _____

For what reason? _____

Do you have any other medical conditions your counselor should be aware of? _____

_____

Are you having any problems with your sleep habits? ☐ No ☐ Yes
If yes, check where applicable:
☐ Sleeping too little ☐ Sleeping too much ☐ Poor quality sleep ☐ Disturbing dreams
Other _____

How many times per week do you exercise? _____Approximately how long each time? _____

Are you having any difficulty with appetite or eating habits? ☐ No ☐ Yes
If yes, check where applicable: ☐ Eating less ☐ Eating more ☐ Binging ☐ Restricting
Have you experienced significant weight change in the last 2 months? ☐ No ☐ Yes

Do you regularly use alcohol? ☐ No ☐ Yes If yes, in a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

How often do you engage in recreational drug use?
☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never
If you used to use recreational drugs how often did you use them and how long ago?
☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never How long ago? _____

Are you currently in a romantic relationship? ☐ No ☐ Yes
If yes, how long have you been in this relationship? _____
If yes, on a scale of 0-10 with 10 as best, how would you rate the quality of your current relationship?___

Psychological History

Have you had suicidal thoughts recently?
☐ NOW ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never (if never, skip to next page)
If yes, do you or did you have a plan? ☐ No ☐ Yes What plan? _____
Did you have a means to carry it out? ☐ No ☐ Yes How? _____
Over **what issue** and **when** was suicide considered? _____
_____
Have you ever attempted suicide before? _____If so, when? _____
Has anyone you know recently committed suicide? _____
Do you have thoughts or hear voices telling you that you would be better off dead? _____
On a 0 (none) to 10 (severe) scale please put in a number indicating the depth of your feelings:
Depressed ___; Hopeless ___; Angry ___; Intent on dying ___;
Who or what is there to live for? _____
Have you had suicidal thoughts in the past? ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never
In the last year, have you experienced any significant life changes or stressors: _____
_____

Please check any problem you have had. (If you are in a relationship indicate what your spouse has (or had) by putting H for Husb. or W for Wife .) If the problem is one with different degrees of severity, how severe was the problem (**0 = none; 10 = severe**)

Issue (please check)	Past	Now	Never	How bad 0-10	H or W & when began
Alcohol abuse					
Substance abuse					
Traumas					
Abused/neglected as a child					
Rape or sexual abuse					
Depression					
Anger					
Anxiety					
Abortion					
Divorce					
Marital infidelity					
Gay/lesbian issues					
Unresolved family issues					
Unresolved issues of grief					
Spousal abuse					
other: (please specify below)					

Have you ever experienced…	Past	Now	Never	How bad? 0 – 10, when began
Extreme depressed mood				
Wild Mood Swings				
Rapid Speech				
Extreme Anxiety				
Panic Attacks				
Phobias (to what?)				
Hallucinations				
Unexplained losses of time				
Unexplained memory lapses				
Frequent Body Complaints				
Eating Disorder				
Body Image Problems				
Repetitive Thoughts e.g., Obsessions				
Repetitive Behaviors (Checking, Hand-Washing, etc)				
Homicidal Thoughts				
Suicide Attempt: If so, when?				When:

FAMILY MENTAL HEALTH HISTORY:

Has anyone **in your family** (either immediate family members or relatives) **other than you** experienced difficulties with the following?

Difficulty			**Family Member**
Depression:	☐ No	☐ Yes	_____
Bipolar Disorder:	☐ No	☐ Yes	_____
Anxiety Disorders:	☐ No	☐ Yes	_____
Panic Attacks:	☐ No	☐ Yes	_____
Schizophrenia:	☐ No	☐ Yes	_____
Alcohol abuse:	☐ No	☐ Yes	_____
Substance Abuse:	☐ No	☐ Yes	_____
Eating Disorders:	☐ No	☐ Yes	_____
Learning Disabilities:	☐ No	☐ Yes	_____
Trauma History:	☐ No	☐ Yes	_____
Suicide Attempts:	☐ No	☐ Yes	_____

OCCUPATIONAL INFORMATION:

Are you currently employed? ☐ No ☐ Yes

If yes: what is your current position? _____

Are you happy at your current position? _____

Please list any work-related stressors, if any: _____

_____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? ☐ No ☐ Yes

If yes, what is your faith? _____

Do you go to church? ☐ No ☐ Yes. If yes, which one? _____

How many times per month? ____ OR per year? _____

If not religious, do you consider yourself to be spiritual? ☐ No ☐ Yes

In what in what way?_____

_____

TREATMENT PLAN INFORMATION:

What do you consider to be your strengths? (personal, family, vocational, recreation, social, cultural, community resources, etc.) _____
_____

What do you like most about yourself? _____
_____

What are effective coping strategies that you've learned? _____
_____

What are your goals for therapy?

a. _____

b. _____

c. _____

What is the first thing that you will notice that will let you know that things are getting better?
_____
_____

What have you tried thus far to address this problem? _____
_____
_____
_____

What do you think has stopped or is stopping you from successfully addressing this problem?
_____

What other needs do you have? (personal, family, vocational, recreation, social, cultural, community resources, etc.) _____
_____

Is there anything else you feel it's important for me to know? _____
_____

_____ _____
Client Signature **Date**

(Print name) _____