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?

Name	Age	Comment	Bio, Step, Adopted
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

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).

Substance	**Amount**	**Frequency**	**Age of 1st use**	**Age regular use started**	**Last use**
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

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