



Counseling Intake

Date _____

Your Full Name _____ Age _____

Spouse's Full Name _____ Age _____

Children's Names _____ Age _____

_____ Age _____

_____ Age _____

_____ Age _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Permission to text? Yes No Permission to leave voicemail? Yes No

Are you interested in on-line/virtual counseling? Yes No

What's your availability? Mon Tues Wed Thurs Morning Afternoon/Evening

Counseling History

Have you or your family ever received counseling for any reason? Yes No

When? _____ What Reason? _____

What type of counseling are you seeking?

Financial Marital Pre-Marital Other

Reason for seeking counseling now:



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How long have you been experiencing this difficulty/challenge?

What goals do you hope to achieve through counseling?

Are you presently working with any other counselor or psychiatrist? Yes No

What reason? _____

How long? _____ Counselor Name/Agency _____

Family History

List any relatives with a history of emotional or mental disorder or suicide (include diagnosis and treatment if known):

List any relatives with a history of alcoholism or excessive alcohol or drug use:

List any significant past trauma experienced by you or those close to you (i.e. death, divorce, sickness, crime, etc.):



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Religious History

In what religious faith were you raised? _____

Present affiliation or name of church you attend? _____

Have you accepted Jesus as your Lord and Savior? Yes No Unsure

If yes, when did you accept Him? _____

Have your religious experiences and training helped or hurt your ability to deal with your struggles? _____

How often do you read your Bible? _____

Do you have a regular time to pray? _____

Have you had any unusual "religious experiences"? Yes No

If yes, please explain: _____

Select any losses that you have experienced:

- | | |
|---|--|
| <input type="radio"/> death of a spouse | <input type="radio"/> suicide |
| <input type="radio"/> child | <input type="radio"/> miscarriage |
| <input type="radio"/> father | <input type="radio"/> abortion |
| <input type="radio"/> mother | <input type="radio"/> adoption |
| <input type="radio"/> sister | <input type="radio"/> infertility |
| <input type="radio"/> brother | <input type="radio"/> bankruptcy |
| <input type="radio"/> grandmother | <input type="radio"/> homelessness |
| <input type="radio"/> grandfather | <input type="radio"/> career or job loss |
| <input type="radio"/> aunt or uncle | <input type="radio"/> divorce |
| <input type="radio"/> other _____ | |



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Check any concerns or issues you have now or in the past:

NOW	PAST
_____	_____ alcohol
_____	_____ academic issues
_____	_____ parent-child communication
_____	_____ Attention Deficient Hyperactivity Disorder
_____	_____ peer pressure
_____	_____ suicidal thoughts ___ suicidal attempt ___ suicidal threat ___
_____	_____ drugs _____
_____	_____ prescription drugs _____
_____	_____ binge eating, excessive dieting or exercise, purging
_____	_____ shopping
_____	_____ working too much
_____	_____ procrastination
_____	_____ communication
_____	_____ depression
_____	_____ anger/rage
_____	_____ grief
_____	_____ anxiety
_____	_____ sexual abuse ___ physical abuse ___ emotional base ___ verbal abuse ___
_____	_____ gender identity
_____	_____ sex
_____	_____ pornography
_____	_____ career
_____	_____ loneliness
_____	_____ mood swings
_____	_____ low self-esteem ___ self-hatred ___



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- _____ co-dependency
- _____ stress
- _____ fear _____
- _____ negative or troubling feelings about church or God
- _____ cutting or self-injury
- _____ addiction _____
- _____ Post Traumatic Stress Syndrome