REVISION
CHRISTIAN COUNSELING

Confidential Client Intake Form

Please bring this completed form to your first appointment. All information contained herein is confidential in accordance with the HIPAA Privacy Act. This information is requested to obtain the best level of treatment.

Name: _____Today's Date: _____

PRESENT ISSUES AND GOALS

Check any of the following symptoms or problems that you have experienced in the **past year**:

□ Debilitating Stress	□ Marital Problems	□ Poor Concentration	□ Anxiety
□ Pregnancy	□ Hallucinations/Delusions	□ Panic	□ Eating Problems
□ Abortion	□ Depression	□ Hearing Voices	□ Sexual Problems
□ Miscarriage	□ Racing Thoughts	□ Fatigue/Lack of Energy	□ Use of pornography
□ Social Anxiety	□ Numbness	□ Drug/Alcohol Use	□ Gender Identity Issues
□ Trouble Sleeping	□ Habitual Anger	□ Addiction	□ PMS/Menstrual Problems
□ Aggressive Behavior	□ Legal Matters	□ Recent Death	□ Bad Dreams
□ Work Stress	□ Grief	□ Chronic Pain	□ Obsessive Thoughts
□ Career Choices	□ Unwanted Memories	□ Indecisiveness	□ Postpartum Depression
□ Impulsive Behavior	□ Parenting Problems	□ Fears/Phobias	□ Other: _____
□ Financial Problems	□ Low Self-Esteem	□ Controlled by Others	□ Other: _____
□ Loneliness	□ Controlling	□ Spiritual Problems	□ Other: _____

Please circle the number that best indicates how distressing your problems are to you currently

1 2 3 4 5 6 7 8 9 10

Minimally distressed Moderately distressed Extremely Distressed

Please describe why you are coming to counseling. How long has this been going on? (Brief explanation)

_____

_____

_____

_____

_____

What do you hope to gain from this counseling experience? _____

_____

_____

_____

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PSYCHOSOCIAL INFORMATION

Please check the level of education you have completed: □HS Graduate □GED □some college □AA/ 2 yrs college □BA/BS/4 yrs college □Some graduate school □MA/2 yrs graduate □Ph. D/4+yrs graduate school □Post-graduate studies

Occupation/Daily Work_____ Level of satisfaction with your occupation_____
Were you "held back" or placed in special education classes? □ Yes □ No If yes, was this helpful to you? _____
Have you been diagnosed with any learning disabilities? □ Yes □ No If yes, what? _____
Do you regularly attend a church or other religious institution? □Yes □No
If yes, which one and how long?_____

Religious background, practice, and spiritual goals, if applicable: _____

_____

_____

How much would you like your counselor to address God/spirituality in sessions? □ Often □ As needed □ Rarely □ Never

RELATIONAL INFORMATION

Have you ever had a protective/restraining order in place against another person? □Yes □No
If yes, against whom?_____
Have you ever filed a protective order and either withdrawn or had it ruled against? □Yes □No
Has anyone ever filed a protective order against you? □Yes □No

Current Relationship Status

Single?	
Married how long?	□1st □2nd □3rd marriage other:
Separated how long?	
Engaged how long?	Plan to marry: □Yes/When: □ No
Cohabitating how long?	
Divorced how long?	
Remarried how long?	
Widowed how long?	

If married, spouse's name: _____ Age: _____
Number of previous marriages for your spouse: _____
Is your spouse supportive of you seeking counseling? □Yes □No □Unsure □Spouse doesn't know

Please list your children (including biological, step, adopted, foster, stillborn, miscarriage, deceased, as applicable):

Name	Sex	Age	Relationship to you	Living with whom?

Who else lives with you? _____

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In the past year, how often have you:

Fought with your significant other	□Never	□Seldom	□Sometimes	□Often	□N/A
Fought with your parent(s)	□Never	□Seldom	□Sometimes	□Often	□N/A
Threatened to hurt your significant other	□Never	□Seldom	□Sometimes	□Often	□N/A
Physically fought with your significant other	□Never	□Seldom	□Sometimes	□Often	□N/A
Thrown things around the house	□Never	□Seldom	□Sometimes	□Often	□N/A
Lost control disciplining your children	□Never	□Seldom	□Sometimes	□Often	□N/A
Had trouble controlling your anger	□Never	□Seldom	□Sometimes	□Often	□N/A
Been arrested?	□None	□1	□2-3	□4-6	□7-9	□10+
Been convicted of a crime? (disregard traffic violations)	□None	□1	□2-3	□4-6	□7-9	□10+

FAMILY OF ORIGIN HISTORY

How well did your parents/guardians get along with each other? □ Great □ Good □ Fair □ Poor □ Terrible
How well did you get along with your parents/caregivers? □ Great □ Good □ Fair □ Poor □ Terrible

How were you disciplined by your parents/caregivers (check all that apply)

□ Never disciplined	□ Talked to about problem	□ Yelled at by parent/guardian	□ Spanked on bottom
□ Slapped on hand	□ Spanked with belt/twig/switch	□ Face slapped	□ Mouth washed out with soap
□ Whipped on back	□ Time out on chair/corner	□ Locked in small room	□ not allowed to eat/drink

Did you ever run away from home? □Yes □ No If yes, how many times? _____

Please list your parents/caregiver(s) and sibling(s).

Name	Sex	Age (or year of death)	Relationship to You

COUNSELING HISTORY/PREVIOUS MENTAL HEALTH CARE

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the names of the therapists or programs. (Use another page if necessary.)

Therapist's Name or Program	Major Issue	Dates

Has anyone in your immediate family ever struggled with substance abuse or mental health issues? □ Yes □ No
Have any of your family members or close friends ever attempted or committed suicide? □ Yes □ No
Have you ever attempted suicide in the past? □ Yes □ No
Use of alcohol: □None □Number of drinks per week: _____
Have you ever been to AA, Al-Anon, NA, SA, Celebrate Recovery or another addiction group? _____

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TRAUMA HISTORY

Have you ever experienced:

Natural Disaster (tornado, earthquake, flood, fire, etc.)	□Yes	□No
Abuse (physical, sexual, spiritual, verbal, emotional, neglect)	□Yes	□No
Combat/War/Terrorism	□Yes	□No
Violence	□Yes	□No
Neglect	□Yes	□No
Serious Car Accident	□Yes	□No
Serious Injury or Illness	□Yes	□No
Near-Death Experience	□Yes	□No

Other:_____

MEDICAL HISTORY

Please list any conditions, illnesses, treatments, or surgeries that might be relevant to your reason for seeking counseling:

_____

Are you currently receiving any medical (including psychiatric) treatment? □Yes □No If yes, please describe:

_____

_____

Have you ever had a head injury, a concussion, or lost consciousness? _____

Please list all medications and herbal remedies

Name of Medication	Dose	Used for

Date and outcome of last physical exam:

_____

_____

_____

I have answered all questions truthfully and to the best of my ability to be able to achieve the best clinical outcome.

_____ _____

Client's Signature Date

Please bring this form with you to your first appointment and give to your counselor directly.