Name: ______________________________ Gender: ________________
Address: ______________________________ City: __________ Zip: ________
Primary Phone Number: __________________we leave a message here: ❑ Yes ❑ No
Second Phone Number: ________________ May we leave a message here: ❑ Yes ❑ No
Birth date: _____ / ______ /______ Age: _______ Preferred Pronouns: ________________
Email Address: ____
Occupation/Employer: __________________________ Avg. Hours/Week: _________
If you are a student what school do you attend? ____________________________
Highest degree(s) earned: ________________

Marriage & Family Information

With whom do you currently live? (*Please check all that apply*)
❑Alone ❑ Parent(s) ❑ Spouse ❑ Children ❑ Boyfriend ❑ Girlfriend ❑ Roommate(s): #__________
If you are in a relationship please fill out the following information:
Name of Significant Other_________________________________ Age _______
Address: (❑ same as above) ___________________________________
Phone #: ________________ Email Address: _________________________
Occupation /Employer or School: _______________________________
Are they willing to come to counseling? ❑ Yes ❑ No ❑ Uncertain
If you are married please provide the information below:
Date of Marriage: ______________ Your age when you married: _______ Spouse's Age ________
Have you ever been separated? ❑ Yes ❑ No ❑ Currently When/How long? ________________
Length of steady dating: ______________ Length of engagement: ________________

Children:

Child's Name	Age	Gender	Living	At Home	Married	Special Condition(s) (i.e. adopted, previous marriage)
			Y/ N	*Y/N*	*Y/N*	

If you have been divorced please fill in the boxes below: *(please use the back of page if you need more space)*

Ex-Spouse's Name	Years Married	Length of Marriage	Reason for Divorce	# Kids

Number of brothers: _____ sisters: ______ The town I grew up in was: ❑ urban ❑ suburban ❑ rural
My family's financial situation was ❑ poor ❑ middle class ❑ wealthy

Number of times you have moved before the age of 18 _______

Did you ever have any significant traumatic events as a child? If yes please briefly describe:
____
____
____
____

Please describe any family history (the family you grew up in), which might be pertinent to the concerns that you bring to counseling (your relationship with you parents, their relationship with each other, significant losses or events etc):
____
____
____

Faith

How much does religious faith play in your life? ❑ None at all ❑ A little bit ❑ Mildly ❑ Very much so
Do you attend worship somewhere on a regular basis? ❑ Yes ❑ No
If yes, please share where: ________________________________ How often? ______________

Health Information

Have you had counseling before? ❑ Yes ❑ No Have you seen a psychiatrist before? ❑ Yes ❑ No

Age	Duration	Counselor / Center	Issue(s) / Topic(s) /Diagnosis	Your evaluation of Counseling

Approximately how many hours of sleep do you get each night? _____
When do you normally go to bed? ____________
Describe any recent changes in sleep habits: ____
State of health: ❑ Very good ❑ Good ❑ Average ❑ Declining ❑ Other: ____________
Date of last medical examination: _____________ Results: ______________________________
Current illness, injury, or disability: ____
Are you presently taking any medication? ❑ Yes ❑ No Prescribing Doctor(s): ________________
____

Medication	Dosage	Frequency	Prescribed for…	Date began taking…

(please use the back of page if you need more space)

Have you used drugs for other than medical purposes? ❑ Yes ❑ No
If currently: What do you take? ______________________ How often ___________ How much? _____________
If in the past how long ago? ______________ What did you take? ____
Do you drink alcoholic beverages? ❑ Yes ❑ No How often ____________ How much? ______________
Have you had any changes in your diet in the past 6 months? ❑ Yes ❑ No
If you have an exercise routine, please describe: ____
Current weight? _____ lbs Weight changes:
6 months +/- ______ lbs **1 Year** +/- ______ 5 **Years** +/-_______
Number of non-working hours you spend watching television ______ on computer ______ hobbies ______
Please check any of the following physiological symptoms that apply to you.

Headaches ……….. ❑ Past ❑ Present
Rapid Heart Rate.. ❑ Past ❑ Present
Tension…………….. ❑ Past ❑ Present
Weakness…………... ❑ Past ❑ Present
Pain…………………... ❑ Past ❑ Present
Change In Appetite ❑ Past ❑ Present
Difficult Breathing……………. ❑ Past ❑ Present
Visual Troubles………………... ❑ Past ❑ Present
Dizziness….………………...…….. ❑ Past ❑ Present
Fatigue………………… …..…….. ❑ Past ❑ Present
Sleep Trouble…………………... ❑ Past ❑ Present
Other (on back)………………... ❑ Past ❑ Present

Check any of the following struggles you and /or your family are experiencing at this present time:
Please rate: "leave blank for none; "1" if mild; "2" if moderate; or "3" for severe.

You	*Family*		*You*	*Family*		*You*	*Family*	
		Abuse, Physical			*Gender dysphoria*			*Pornography*
		Abuse, Sexual			*Greed*			*Pride*
		Abuse, Verbal			*Grief*			*Priorities*
		Abuse in the past			*Guilt*			*Procrastination*
		Addiction			*Identity*			*Purpose, Lack there of*
		Anger			*Impatience*			*Rebellion*
		Anxiety			*Infertility*			*Rejection*
		Apathy			*Insecurity*			*Relationships*
		Bitterness			*In-Law conflict*			*Respecting authorities*
		Caring for parents			*Jealousy*			*Same sex attraction*
		Codependency			*Lifestyle change*			*Self-control*
		Compulsions			*Loneliness*			*Self-injury*
		Depression			*Lying*			*Selfishness*

		Debt			*Manipulation*			*Sex issues*
		Discontentment			*Marital intimacy*			*Shame*
		Divorce recovery			*Moodiness*			*Social anxiety*
		Eating disorder			*Panic attacks*			*Spiritual growth*
		Empty nest			*Parenting*			*Submission*
		Envy			*Parenting adult child*			*Suicidal thinking*
		Fear			*People pleasing*			*Time management*
		Financial management			*Perfectionism*			*Work unfulfilling*

- ***If issues not covered please write in empty spaces***

Please complete the following:

In order to understand me ____

____

My ambition in life is to ____
What really hurts me ____
I get nervous when ____
I wish I could lose my fear of ____
What I wish I could change about myself ____
My best childhood memory ____
My worst childhood memory ____
My father was/is ____
My mother was/is____
My greatest achievement is ____
My role in my current family is ____
For refuge / rest I turn to ____
When life gets too tough I ____
To be happy I need ____
I would do anything for ____
I often wonder why ____
It would embarrass me to ____
I cannot decide ____

Indicate how distressed you are by placing an "x" on the scale below (1 = very little distress; 10 extreme distress):

1 2 3 4 5 6 7 8 9 10

1) Please describe the issue (s) that bring you to counseling ________________

2) What have you done about it so far? ________________

3) Other than counseling, what help are you seeking? ________________

4) What are your expectations coming here? ________________

5) What are your concerns coming to counseling? ________________

6) What do you believe has to change to produce the progress you desire?

7) Is there any other information we should know? ________________

Thank you for your time in filling this intake form.
It helps our counselors have a better sense of who you are.