Cleanwaters Counseling
Ministries

INFORMATION INTAKE FORM (IIF)

IDENTIFICATION DATA:

Name: ________________________________Phone: _______________________

Address:____

Occupation: _______________________ Business Phone: ___________________

Email:___________________________________

Sex: ______ Birth Date: ____________ Age: ______ Height: ______

Marital Status: Single____ Going Steady____ Engaged ____
Married ____ Separated ____ Divorced ____ Widowed ____

Education (last year completed): ________ (grade)

Other training (list type and years):
____

Referred here by: _________________________ Address: _______________________

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HEALTH INFORMATION:

Rate your health (check): Very Good ____ Good ____ Average ____

Declining ____ Other ____

Your approximate weight: _____ (lbs.) Weight changes recently: Lost ___ Gained____

List all important present or past illnesses or injuries or handicaps:

____

____

____

____

Date of last medical examination? ________ Report: _____________________
____
____
____
____

Your physician: ___________________ Address:___________________________

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Are you presently taking medication?   Yes ______ No ______ What: ____________

____

Have you used drugs for other than medical purposes?   Yes ______ No ______

What?
____

How many hours of sleep do you average per night? _______   Have there been any recent changes? _______   Is this sleep restful? ______   Do you have trouble sleeping?

____

Have you had any of the following physical problems?   Please check:

___Heart Problems   ___ Liver Problems   ___Visual Problems   ___Hallucinations

___Weakness   ___ Problems Walking ___ Unusual Hair loss   ___Allergies

___Blackouts   ___ Amnesia   ___Impotence   ___Rashes

___Constant Hunger   ___Food Cravings   ___Headaches   ___Kidney problems

___Stiff Neck   ___Bulimia   ___Anorexia   ___Personality change

___Seizures   ___Brain Tumor   ___Changes in Sexual Drive

___Bowel/bladder   ___Nausea/Vomiting   ___Weight Change

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___Deja vu ___Lung Problems ___Menstrual Irregularities

___Cancer ___High Blood Pressure ___Fatigue

___Head Stroke ___Injury/Concussion ___Sensory Distortion

___Memory Problems __Pneumonia ___Parkinson Disease

___Speech Problems __Coordination Problems ___Dizziness

Have you ever been arrested? Yes ____ No ____ Explain:_____________________

____

Are you willing to sign a release of information form so that your counselor may write for social, psychiatric, or medical reports? Yes ____ No ____

Have you recently suffered the loss of someone who was close to you? Yes ____

No ____ Explain:

____

Have you recently suffered the loss of a job or business?

Yes ____ No ____ Explain: ____

____
_

RELIGIOUS BACKGROUND:

Denominational preference:

____

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Church Attendance per month (circle): 0 1 2 3 4 5 6 7 8 9 10+

Church currently attending: ______________________ How long: ________

Church address:____

Pastor's/Elder's name: _________________________ Have you discussed this problem with your pastor/elders?
____

Baptized? Yes ____ No ____When? __________

Religious background in childhood: _______________________________________

Religious background of spouse/fiancée? ___________________________

Have you ever been disciplined by a church? Yes _____ No _____ Uncertain____

Do you consider yourself a religious person? Yes _____ No _____ Uncertain _____

Do you believe you will go to heaven when you die?
____

Do you believe in God? Yes ______ No ______ Uncertain ______

Are you saved? Yes _______ No _______ Not sure what you mean___________________

If yes, please provide your testimony:____
____
____
____
____
____
____
____
____

How much do you read the bible? Never _______ Occasionally ______ Often ______

Do you have regular family devotions? Yes ______ No _____

Explain recent changes in your religious life, if any: ______________________________
____
____

PERSONALITY INFORMATION:

Have you ever had any psychotherapy or counseling before? Yes _____ No _______

If yes, list counselor or therapist and dates: _____________________________________
____

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____

____

What was the outcome? ____

____

Circle any of the following words which best describe you now: active/ ambitious/

self-confident/ persistent/ nervous/ hardworking/ impatient/ impulsive/ moody/ often-blue/ excitable/ imaginative/ calm/ serious/ easy-gong/ shy/ good-natured/ introvert/ extrovert/ likeable/ leader/ quiet/ hard-boiled/ submissive/ lonely/ self-conscious/
sensitive/other:____

Have you ever had hallucinations? Yes _____ No _____

Do you have any uncontrollable fears? Yes ____ No ___ Explain: _______________

____

Do you have problems sleeping? Yes _____ No _____

MARRIAGE AND FAMILY INFORMATION:

Name of spouse: _________________
Address:_______________________________

Phone: ________________ Occupation: ____________________________

Business phone: ___________________________________

Your spouse's age: ____ Education (in years) _____ Religion: ____________________

Is spouse willing to come for counseling? Yes _____ No _____ Uncertain _____

Have you ever been separated? Yes ____ No ____

When? _______ from______ to ______

Has either of you ever filed for divorce? Yes _____ No _____ When?
____

Reason for divorce: Adultery_____ Other_____ Explain: _______________________
____

Date of Marriage _________Your ages when married: Husband _____ Wife ______

How long did you know your spouse before marriage?
____

Length of steady dating with spouse: __________Length of Engagement:_________

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Give brief information about any previous marriages:
____
____

Information about children:

PM* Name Age Sex Living (Yes or No) Education in years Marital Status

____

____

____

____

____

*Place an asterisk if child is by previous marriage.

If you were reared by anyone other than your own parents, briefly explain:____
____

How many older brothers ______ sisters ______ do you have?

How many younger brothers _______ sisters ______ do you have?

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BRIEFLY ANSWER THE FOLLOWING QUESTIONS:

1. What is your problem?

____
____
____
____
____
____
____
____

2. What have you done about it?

____
____
____
____

3. What can we do? (What are your expectations in coming here?)

____
____
____
____

4. As you see yourself, what kind of person are you? Describe yourself.

____
____
____
____

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5. What, if anything, do you fear?

____
____
____
____

6. Is there any other information we should know?

____
____
____
____
____
____
____