INTAKE INFORMATION FORM

IDENTIFICATION DATA:

Name: _____ Phone: _____

Address: _____

Occupation: _____ Business Phone: _____

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 by: _____ Address: _____

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: _____

Are you presently taking medication? Yes ____ No ____ What: _____
_____

Have you used drugs for reasons 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
___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: _____

Church Attendance per month (circle one): 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 as a child: _____

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 often 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: _____

_____
_____
_____

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

Have you ever been separated? Yes ____ No ____
When? _____ from _____ to _____

Have 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: _____

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?

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.

5. What, if anything, do you fear?

6. Is there any other information we should know?