CENTRAL

Biblical Teaching | Passionate Worship | Authentic Ministry

# CLIENT INTAKE FORM

## Client Information

Name: _____ Birthdate: _____ Gender: _____

Address: _____

Is it safe to send correspondence to this address, if needed? ☐ Yes ☐ No

Phone: (Home) _____ (Work) _____ (Cell) _____

Is it safe to contact/leave you a message at these numbers? ☐ Yes ☐ No

E-mail: _____ Highest Education Attended: _____

Occupation: _____ Place of Employment: _____

Relationship Status: _____ Spouse/Significant Other's Name: _____

## Persons Living With You

| Relationship | Name | Gender | Age | Quality of Relationship |
|---|---|---|---|---|
| _____ | _____ | ☐F ☐ M | ____ | ☐ Poor ☐ Average ☐ Good |
| _____ | _____ | ☐F ☐ M | ____ | ☐ Poor ☐ Average ☐ Good |
| _____ | _____ | ☐F ☐ M | ____ | ☐ Poor ☐ Average ☐ Good |
| _____ | _____ | ☐F ☐ M | ____ | ☐ Poor ☐ Average ☐ Good |

## Social Relationships

Check how you generally get along with other people: (check all that apply)

☐Affectionate ☐Aggressive ☐Avoidant ☐Fight/argue often ☐Outgoing ☐Follower

☐Friendly ☐Leader ☐Shy/withdrawn ☐Submissive

Other (Specify): _____

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OFFICE: (979) 776-9977 • FAX: (979) 776-3807 • COUNSELING: (979) 314-4099

## Spiritual/Religious

Family's religious affiliation(s): _____ Practicing: ☐ Yes ☐ No

How important are spiritual matters to you? ☐ Not ☐ Somewhat ☐ Moderately ☐ Very

Are you personally affiliated with a spiritual or religious group? ☐ Yes ☐ No

If yes, describe: _____

_____

_____

Were you raised within a spiritual or religious group? ☐ Yes ☐ No

If yes, describe: _____

_____

_____

How would you like for your spiritual beliefs incorporated into your counseling session(s)? ____

_____

_____

## Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong to? _____

Are you experiencing any problems due to cultural or ethnic issues? ☐ Yes ☐ No

If yes, describe: _____

_____

Other cultural/ethnic information you'd like to have known: _____

_____

## Legal

Are you involved in any active cases (traffic, civil, criminal)? ☐ Yes ☐ No

If yes, please describe and indicate the court and hearing/trial dates and charges: _____

_____

_____

Have you ever been convicted of a felony? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

Are you presently on probation or parole? ☐ Yes ☐ No

If yes, please describe:_____

_____

_____

## Military

Military experience? ☐ Yes ☐ No Combat experience? ☐ Yes ☐ No

Where: _____

Branch: _____ Discharge date: _____ Discharge type: _____

Date drafted/enlisted: _____ Rank at discharge: _____

## Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, hunting, fishing, bowling, traveling, etc.)

| Activity | How often now? | How often in the past? |
|---|---|---|
| | | |
| | | |
| | | |

**Medical**

List any current health conditions: _____

_____

_____

| Current Medication(s) | Dose | Last Taken | Purpose | Side Effect(s) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Psychosocial History**

Please check behaviors and systems which apply to you in the last four to six weeks:

☐ Aggression ☐ Elevated Mood ☐ Phobias/Fears ☐ Alcohol Dependency ☐ Fatigue

☐ Recurring Thoughts ☐ Anger ☐ Gambling ☐ Sexual Addiction ☐ Antisocial Behavior

☐ Hallucinations ☐ Sexual Difficulties ☐ Anxiety ☐ Heart Palpitations ☐ Sick Often

☐ Avoiding People ☐ High Blood Pressure ☐ Sleeping Problems ☐ Chest Pain

☐ Hopelessness ☐ Speech Problems ☐ Cyber Addiction ☐ Impulsivity ☐ Suicidal Thoughts

☐ Depression ☐ Irritability ☐ Disorganized Thoughts ☐ Disoriented ☐ Judgment Errors

☐ Trembling ☐ Distractibility ☐ Loneliness ☐ Withdrawing ☐ Dizziness ☐ Memory Impairment ☐ Worrying ☐ Drug Dependence ☐ Mood Shifts ☐ Eating Disorder ☐ Panic Attacks ☐ Other (specify): _____

Describe any other symptoms you may have experienced during the past four to six weeks: ____

_____

_____

_____

_____

_____

Do you use alcohol? ☐ Yes ☐ No

If yes, please describe: _____

_____

Do you use drugs? ☐ Yes ☐ No

If yes, please describe: _____

_____

Have you ever considered suicide? ☐ Yes ☐ No Have you attempted suicide? ☐ Yes ☐ No

Have you considered suicide within the last 60 days? ☐ Yes ☐ No Attempted? ☐ Yes ☐ No

Are you currently considering suicide? ☐ Yes ☐ No

Do you have a specific plan that you could describe? _____

_____

_____

Have you ever received counseling/psychiatric treatment before? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

If you or anyone in your house hold has a history with any of the following, please select all that apply:

☐ Physical Abuse Family Member / Age: _____
☐ Sexual Abuse Family Member / Age: _____
☐ Emotional Abuse Family Member / Age: _____
☐ Neglect Family Member / Age: _____
☐ Drug Abuse Family Member / Age: _____
☐ Alcoholism Family Member / Age: _____
☐ Domestic Violence Family Member / Age: _____
☐ Psychiatric Difficulties Family Member / Age: _____
☐ Criminal Difficulties Family Member / Age: _____
☐ Other: _____ Family Member / Age: _____

Please list any other information that you think the counselor should know: _____

_____

_____

_____

_____

_____

What are your goals for therapy? _____

_____

_____

_____

_____

_____