CHRISTIAN COUNSELING ASSOCIATES

A MINISTRY OF CORNERSTONE LODGE, INC.

INTAKE SHEET

CLIENT INFORMATION

Primary Client ____
Last Name First Name MI Nickname

Address ____
Street City State Zip

Home Phone ________________ Work ________________ Cell _________________________
Email ____
Date of Birth ______________________ Age ___________ Gender __________________
Occupation ____
May we call you at your home? _____ Yes _____ No
May we call you at your office? _____ Yes _____ No
May we call you on your cell? _____ Yes _____ No
May we leave a message at your home? _____ Office? _____ Cell? _____

Current Marital Status:
___ Never Married ___ Married ___ Engaged ___ Divorced
___ Separated ___ Widowed

Name of Spouse (if applicable) or Parents (if client is a minor)___________________________
Date of Marriage ____

Name of other family members:
_________________________ Age ____ Gender ____ Relationship ____________________
_________________________ Age ____ Gender ____ Relationship ____________________
_________________________ Age ____ Gender ____ Relationship ____________________
_________________________ Age ____ Gender ____ Relationship ____________________
_________________________ Age ____ Gender ____ Relationship ____________________

Your Education Level: ___ GED ___ High School Diploma
___ College Degree ___ Graduate Degree Degree In _____________________
Spouse's Education Level: ___ GED ___ High School Diploma
___ College Degree ___ Graduate Degree Degree In _____________________
Previous Marital History (if applicable):
SELF:

Name of Previous Spouse	Date of Marriage	Date of Divorce/Death
_____________________	________________	__________________
_____________________	________________	__________________
_____________________	________________	__________________

SPOUSE:

Name of Previous Spouse	Date of Marriage	Date of Divorce/Death
_____________________	________________	__________________
_____________________	________________	__________________
_____________________	________________	__________________

PERSONAL INFORMATION

Are you currently attending a church? ____ Yes ____ No
If yes, what is the name of the church? ______________________________
What is the denomination of the church? ______________________________
Do you have a personal relationship with Christ? ____ Yes ____ No ____ Unsure
Are religious or spiritual issues important in your life? ____ Yes ____ No
Are you aware of any religious or spiritual resources in your life that could be used to help you overcome your problems? ____ Yes ____ No
If yes, what are they? ______________________________
Would you like prayer as part of your counseling? ____ Yes ____ No
Who referred you to our center? ______________________________
May we contact them? ____ Yes ____ No
How would you rate your health? ______________________________
How many hours do you sleep each night? ______________________________
How would you rate your diet? ___ Very Healthy ___ Healthy ___ Average
___ Needs Improvement ___ Poor
Do you have addictive/abusive issues with: ___ Alcohol ___ Illegal Drugs ___ Prescriptions
___ Sex ___ Pornography ___ Gambling ___ Gaming ___ Other: ________________
Has your appetite or weight changed lately? ______________________________
Are you currently on medication? ____ Yes ____ No
If so, please complete the following:

Medication	Dosage	Physician	Purpose

PERSONAL CONCERNS

Briefly explain why you are coming to counseling and what you hope to gain from your experience. ______________________________
____
How much are you troubled by this?
____ Constantly ____ Often ____ Somewhat ____ Not Very Much
Comments concerning this problem: ______________________________
____
Have you been in counseling before? ____ Yes ____ No
If so, for each incidence you remember, please complete the following:

1. Who was the counselor? ______________________________
   What was the problem? ______________________________
   How many sessions over what period of time? ______________________________
   What were the results? ______________________________
2. Who was the counselor? ______________________________
   What was the problem? ______________________________
   How many sessions over what period of time? ______________________________
   What were the results? ______________________________
3. Who was the counselor? ______________________________
   What was the problem? ______________________________
   How many sessions over what period of time? ______________________________
   What were the results? ______________________________

THOUGHTS AND BEHAVIORS

Please check how often the following thoughts occur to you:

1. Life is hopeless. ____ Never ____ Rarely ____ Sometimes ____ Frequently
2. I am lonely. ____ Never ____ Rarely ____ Sometimes ____ Frequently
3. No one cares about me. ____ Never ____ Rarely ____ Sometimes ____ Frequently
4. I am a failure. ____ Never ____ Rarely ____ Sometimes ____ Frequently
5. Most people don't like me. ____ Never ____ Rarely ____ Sometimes ____ Frequently
6. I want to die. ____ Never ____ Rarely ____ Sometimes ____ Frequently
7. I want to hurt someone. ____ Never ____ Rarely ____ Sometimes ____ Frequently
8. I am so stupid. ____ Never ____ Rarely ____ Sometimes ____ Frequently
9. I am going crazy. ____ Never ____ Rarely ____ Sometimes ____ Frequently
10. I can't concentrate. ____ Never ____ Rarely ____ Sometimes ____ Frequently
11. I am so depressed. ____ Never ____ Rarely ____ Sometimes ____ Frequently
12. God is disappointed in me. ____ Never ____ Rarely ____ Sometimes ____ Frequently
13. I can't be forgiven. ____ Never ____ Rarely ____ Sometimes ____ Frequently
14. Why am I so different? ____ Never ____ Rarely ____ Sometimes ____ Frequently
15. I can't do anything right. ____ Never ____ Rarely ____ Sometimes ____ Frequently
16. People hear my thoughts. ____ Never ____ Rarely ____ Sometimes ____ Frequently
17. I have no emotions. ____ Never ____ Rarely ____ Sometimes ____ Frequently
18. Someone is watching me. ____ Never ____ Rarely ____ Sometimes ____ Frequently
19. I hear voices in my head. ____ Never ____ Rarely ____ Sometimes ____ Frequently
20. I am out of control. ____ Never ____ Rarely ____ Sometimes ____ Frequently

Please rate the following symptoms on a scale of 0-2:

0 = Not significant/Non-existent 1 = Moderate/Sometimes 2 = Frequent/Severe

Symptom	Rating	Symptom	Rating
Excessive anger, easily frustrated	____	Hyperactivity	____
Mood swings (depression-manic)	____	Change or loss of friends	____
Excessive guilt or shame	____	Sexual problems	____
Loss of energy	____	Self-mutilation, cutting	____
Loss of interest in activities	____	Excessive stress	____
Suicidal thoughts	____	Anxiety or excessive fears	____
Suicide attempts (how many)	____	Learning disabilities	____
Lying	____	Work or school related problems	____
Manipulation	____	Hallucinations, delusions, thought distortions	____
Poor impulse control	____	Obsessive thoughts &/or compulsive behaviors	____

Please comment (e.g., examples, frequency, duration, effects on you) about each of the above thoughts/behaviors that occur frequently or are a concern to you.

____
____
____
____
____
____
____
____
____
____

EMERGENCY CONTACT

Whom should we contact in case of emergency?

Name ____

Address ____

Home Phone ____________________________ Cell Phone ____________________________