CHRISTIAN COUNSELING ASSOCIATES
YOUTH INTAKE FORM

Primary Client Name:

Street Address:

City: **State:** **Zip:**

Home Phone **Work** **Mobile**

May we call you at your… **home?** **work?** **mobile?**

May we leave a voicemail? **yes** **no**

Email

Birthdate: **Age:** **Gender:** **male** **female**

Please list any other immediate family members:

Name	Age	Relationship to you

GUARDIAN'S INFORMATION

Name **Relationship**

Home Phone **Work** **Mobile**

May we call you at… **home?** **work?** **mobile?**

May we leave a voicemail? **Yes** **No**

Email

Birthdate **Age:** **Occupation**

Marital Status

Wedding Date **Divorce Date** **Death Date**

Education Level

Any other important family info?

Name Relationship

Home Phone Work Mobile

May we call you at… home? work? mobile?

May we leave a voicemail? Yes No

Email

Birthdate Age: Occupation

Marital Status

Wedding Date Divorce Date Death Date

Education Level

Any other important family info?

PERSONAL INFORMATION

Are you attending a church? yes no

Name and denomination?

Do you have a personal relationship with Jesus? yes no Unsure

Are spiritual issues important to you? yes no

Do you have spiritual resources that could 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

Rate your health Rate your diet

How many hours do you sleep each night?

Has your appetite or weight changed lately? yes no

Do you have addictive/abusive issues with: Alcohol Illegal Drugs Prescriptions Sex Porn Gambling Gaming Other:

If you are currently on medication, complete the following:

Medication	Dosage	Purpose	Prescribing Physician

PERSONAL CONCERNS

Why are you coming to counseling and what do you hope to gain from it?

How much are you troubled by this? **Constantly** **Often** **Somewhat** **Not much**

Comments concerning this problem:

Have you been in counseling before? **yes** **no**

If so, for each incidence complete the following:

Counselor's Name	Problem	Duration	Results

THOUGHTS AND BEHAVIORS

How often do the following thoughts occur to you?

Life is hopeless.	Never	Rarely	Sometimes	Frequently
I am lonely.	Never	Rarely	Sometimes	Frequently
No one cares about me.	Never	Rarely	Sometimes	Frequently
I am a failure.	Never	Rarely	Sometimes	Frequently
Most People don't like me.	Never	Rarely	Sometimes	Frequently
I want to die.	Never	Rarely	Sometimes	Frequently
I want to hurt someone.	Never	Rarely	Sometimes	Frequently
I am so stupid.	Never	Rarely	Sometimes	Frequently
I am going crazy.	Never	Rarely	Sometimes	Frequently
I can't concentrate.	Never	Rarely	Sometimes	Frequently
I am so depressed.	Never	Rarely	Sometimes	Frequently
God is disappointed in me.	Never	Rarely	Sometimes	Frequently
I can't be forgiven.	Never	Rarely	Sometimes	Frequently
Why am I so different?	Never	Rarely	Sometimes	Frequently
I can't do anything right.	Never	Rarely	Sometimes	Frequently
People can hear my thoughts.	Never	Rarely	Sometimes	Frequently
I have no emotions.	Never	Rarely	Sometimes	Frequently
Someone is watching me.	Never	Rarely	Sometimes	Frequently
I hear voices in my head.	Never	Rarely	Sometimes	Frequently
I am out of control.	Never	Rarely	Sometimes	Frequently

Rate the following symptoms:

Symptom			
Excessive anger, easily frustrated	**Never**	**Sometimes**	**Frequently**
Mood swings (depression – manic)	**Never**	**Sometimes**	**Frequently**
Excessive guilt or shame	**Never**	**Sometimes**	**Frequently**
Loss of energy	**Never**	**Sometimes**	**Frequently**
Loss of interest in activities	**Never**	**Sometimes**	**Frequently**
Suicidal thoughts	**Never**	**Sometimes**	**Frequently**
Suicide attempts How many?	**Never**	**Sometimes**	**Frequently**
Lying	**Never**	**Sometimes**	**Frequently**
Manipulation	**Never**	**Sometimes**	**Frequently**
Hyperactivity	**Never**	**Sometimes**	**Frequently**
Change or loss of friends	**Never**	**Sometimes**	**Frequently**
Sexual problems	**Never**	**Sometimes**	**Frequently**
Self-mutilation (e.g., cutting)	**Never**	**Sometimes**	**Frequently**
Excessive stress	**Never**	**Sometimes**	**Frequently**
Anxiety or excessive fears	**Never**	**Sometimes**	**Frequently**
Learning disabilities	**Never**	**Sometimes**	**Frequently**
Work or school related problems	**Never**	**Sometimes**	**Frequently**
Hallucinations, delusions, thought distortions	**Never**	**Sometimes**	**Frequently**
Obsessive thoughts and/or compulsive behaviors	**Never**	**Sometimes**	**Frequently**
Poor impulse control	**Never**	**Sometimes**	**Frequently**

Please comment (with examples, frequency, duration, effects on you) about each of the thoughts and behaviors that occur frequently or are a concern to you:

Enter information here if there wasn't room elsewhere:

EMERGENCY CONTACT

Who should we contact in case of an emergency?

Name:

Address:

Home Phone: **Mobile Phone:**

For office use:

Therapist:

Diagnostic code:

Date of first session: fee:

Insurance Carrier: Y N