# CHRISTIAN COUNSELING ASSOCIATES
# CLIENT 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**

**Occupation:**

**Education Level:** Choose One

**Spouse's Education Level:** Choose One

**Marital Status:** Choose One

**Name of Spouse:**

**Marriage Date:**

**Please list any other immediate family members:**

| Name | Age | Relationship to you |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**If you have been married before, please list those marriages:**

| Previous Spouse's Name | Marriage Date | Divorce Date | Death Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**If your spouse has been married before, please list those marriages:**

| Previous Spouse's Name | Marriage Date | Divorce Date | Death Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## 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**

**How would you rate your health?** Choose One

**How many hours do you sleep each night?** Choose One

**How would you rate your diet?** Choose One

**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 |
|---|---|---|---|
| | | | |
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| | | | |

## 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:**

| | |
|---|---|
| **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 ◯