Christian Counseling Associates

Real Heart Real Change 972.422.8383

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
_____	_____	_____
_____	_____	_____
_____	_____	_____

For office use:
Therapist: _____
Diagnostic code: _____
Date of first session: _____ fee _____
Insurance Carrier: _____ Y or N

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

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 _____

FAMILY HISTORY

Mother's Information

Name_____ Age_____
Mental Illness History _____
Abuse History _____
Substance Abuse History _____ Treatment_____
# of Marriages _____ # of Divorces_____

Father's Information

Name_____ Age_____
Mental Illness History _____
Abuse History _____
Substance Abuse History _____ Treatment_____
# of Marriages _____ # of Divorces_____

Who were you raise by?_____

How would you describe your childhood?_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

How do you get along with your family?_____
_____
_____
_____
_____
_____

Sibling History

Do any of your siblings have a history of the following?

Substance Abuse_____
Criminal Activity_____
Mental Illness_____

ABUSE HISTORY / INFORMATION

Have you ever been mistreated? _____

Have you ever been sexually abused? _____
By who? _____
What happened? _____
How often? _____
Did you tell anyone? _____
If so, what happened? _____
How does it affect you today? _____
_____
_____
_____

Have you ever been physically abused? _____
By who? _____
What happened? _____
How often? _____
Did you tell anyone? _____
If so, what happened? _____
How does it affect you today? _____
_____
_____
_____

Was there any domestic violence in your home? _____
What happened? _____
_____
_____
_____
Were the police involved?_____