

Confidential Counseling Intake

Name: _____ Date: _____

Home Address: _____ DOB: ____/____/____ Age: _____

City, State, Zip: _____ SS#: _____ - _____ - _____

Home Phone: (____) _____ - _____ Sex: Male Female

Cell Phone: (____) _____ - _____ Email: _____

Ok to email newsletter? Y N

Employer: _____ Work Phone: (____) _____ - _____

Highest Level of Education: _____ Spouse's _____

May we reach you: Home: Yes No Work: Yes No Cell: Yes No Text: Yes No

May we send mail to you at your home address? Yes No

Marital Status: Never Married Married Widowed Separated Divorced

If Currently Married, how long: _____

Spouse's Name: _____ Age: _____

Children's Names: _____ Age: _____

_____ Age: _____

_____ Age: _____

Please list any other persons living in the home: _____

Previous Marriage: Yes No Name of Previous Spouse: _____ Married How Long? _____

Health & Personal Information

Would you describe your current physical health as: Excellent Good Fair Poor

Would you describe your current diet as: Excellent Good Fair Poor

How many hours do you sleep each night? _____

Do you currently have any physical problems? Yes No If yes, please explain: _____

Please list any medical conditions or any disabilities: _____

Have you or anyone in your family been diagnosed or treated for any mental illness? Yes No If yes, explain:

Have you ever been in counseling before? Yes No If yes, please provide counselor name and location, dates, and reason for counseling: _____

Please list all prescription and OTC medications currently being taken:

<u>Medication</u>	<u>Dosage</u>	<u>Physician</u>	<u>Purpose</u>

Have you ever taken illegal drugs? Yes No

Do you drink alcoholic beverages Yes No How many average per day? _____ per week? _____

Are religious or spiritual issues important to you? Yes No

How much do they influence your daily life? A great deal A reasonable amount Some Very little

Do you currently attend church? Yes No

If yes, where do you attend? _____

How did you hear about Fully Living; Michael Dawson? _____

What concerns are you seeking counseling for today? _____

How often are you troubled by these concerns? Constantly Often Sometimes Not very often

Please indicate your current level of the following symptoms or behaviors:

	Never	Rarely	Sometimes	Frequently
Feeling angry or having outbursts:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling distant from God:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble controlling worry or anxiety:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Life is hopeless:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Withdrawing from relationships:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive use of alcohol or drugs:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of sexual interest:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feelings of depression:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nightmares:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Never	Rarely	Sometimes	Frequently
Afraid of specific places or things:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive recurring thoughts:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having little self-confidence:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I do not deserve to be forgiven:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsession with certain activities:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling of stress, under too much pressure:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood shifts:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am often physically sick:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever been involved in any **Traumatic situations**? If yes, please explain: _____

Family of Origin

Present During Childhood:

	Present Entire Childhood	Present Part of Childhood	Not Present at All	Describe Childhood Family Experience
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Outstanding Home Environment
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Normal Home Environment
Step Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chaotic Home Environment
Step Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Witnessed Abuse toward others
Brother(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Experienced Abuse from others
Sister(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Parents' Current Marital Status:

- | | |
|---|--|
| <input type="checkbox"/> Married to each other | <input type="checkbox"/> Mother involved with someone |
| <input type="checkbox"/> Separated for ___ years | <input type="checkbox"/> Father involved with someone |
| <input type="checkbox"/> Divorced for ___ years | <input type="checkbox"/> Mother deceased for ___ years |
| <input type="checkbox"/> Mother remarried ___ times | Age of client at mother's death ___ |
| <input type="checkbox"/> Father remarried ___ times | <input type="checkbox"/> Father deceased for ___ years |
| | Age of client at father's death ___ |

Emergency Contact

Who should we contact in case of an emergency?

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____ City, State, Zip: _____

Client Signature: _____