GRACE COUNSELING CENTER

Office Use Only

Counselor:

CONFIDENTIAL INTAKE FORM

GENERAL INFORMATION

Date: _____ Referred by: _____

Full name: Mr./Mrs./Ms./Miss/Dr./Rev. _____ Sex: ❑ Male ❑ Female

Name you prefer: _____ Date of birth:_____ Age:_____

Ethnicity: ❑ White ❑ Black ❑ Hispanic ❑ Asian ❑ Other: _____

Mailing address: _____ Suite/Apartment #: _____

City: _____ State: _____ Zip code: _____
May we send mail here: ❑ Yes ❑ No

Home Phone:_____ Call you here? ❑ Yes ❑ No Message here? ❑ Yes ❑ No

Work phone:_____ Call you here? ❑ Yes ❑ No Message here? ❑ Yes ❑ No

Cell phone:_____ Call you here? ❑ Yes ❑ No Message here? ❑ Yes ❑ No
Please indicate *preferred number* to call with an asterisk (*).

Email:_____ Contact you here? ❑ Yes ❑ No

Employer:_____ How long have you been there:_____

Occupation:_____ Average hours worked per week:_____

Highest level of education completed: _____ Are you currently in school? ❑ Yes ❑ No

If Yes, what level? _____ Degree pursuing: _____

Do you regularly attend a place of worship? ❑ Yes ❑No If Yes, where? _____

In case of emergency, contact:

Name:_____ _____ Relationship: _____

Home phone: _____ Cell phone: _____

May we put you on our mailing list to receive Grace Counseling newsletters and program information? Yes No

Would you like to receive our e-mail newsletter? Yes No

RELATIONAL INFORMATION

Current marital status: ❑ Single ❑ Dating ❑ Engaged ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

If dating, engaged, married, separated, divorced, or widowed, for how long?_____

Number of previous marriages for you? _____ For your partner/spouse? _____

Partner's/Spouse's name:_____ Partner's/Spouse's age:_____

Is your partner/spouse supportive of you seeking counseling? ❑ Yes ❑ No ❑ Unsure ❑ He/She doesn't know

What words would you use to describe your partner: _____

With whom do you currently live? (*Check all that apply*)
❑ Alone ❑ Spouse ❑ Children ❑Parent(s) ❑ Sibling(s) ❑ Boyfriend ❑ Girlfriend ❑ Roommate
❑ Other:_____

List your children (including step, adopted, foster) below:

Name	Sex	Age or year of death	Relationship to you	Living with whom?

Have you ever placed a child for adoption? ❑ Yes ❑ No. If Yes, when? _____

Have you ever had a miscarriage or medical abortion? ❑ Yes ❑ No. If Yes, when? _____

List your mother, father, brothers, sisters, step-family relations, or any other family member who had a significant effect (positive or negative) upon your life.

Name	Age or year of death	Relationship to you (e.g., mother, father, sibling, step-relation)	Give 2-3 words to describe this person

COUNSELING HISTORY

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the names of the therapists or programs: *(Use the back, if necessary*)

Therapist's name or program	Major issue	Dates

MEDICAL HISTORY

List any medical conditions, illnesses, treatments, or surgeries:

_____

_____

Your height: _____ Your weight: _____

How has your weight changed in the last 2-3 months: ❑ little or no change ❑ up _____lbs. ❑ down _____ lbs.

List all current medications you are taking, including those you seldom use or take only as needed: *(Use back if necessary)*

Name of medication	Dose	Reason for taking medication

Primary Physician: _____ Phone: _____

Address: _____

Are you presently experiencing any suicidal thoughts? ❑ Yes ❑ No

Have you experienced them in the past? ❑ Yes ❑ No

Have you ever attempted suicide? ❑ Yes ❑ No

If Yes, when and how: _____

Have any of your friends or family ever committed or attempted suicide? ❑ Yes ❑ No

If Yes, when and who: _____

Are you presently experiencing any thoughts of harming other person? ❑Yes ❑No

CURRENT ISSUES

Check any of the following symptoms or problems that you are experiencing or have experienced in the past.

Present	Past		Present	Past		Present	Past	
❑	❑	Abortion	❑	❑	Fears, phobias	❑	❑	Panic/anxiety attacks
❑	❑	Addiction	❑	❑	Hopelessness	❑	❑	Parenting problems
❑	❑	Aggressive behavior	❑	❑	Financial problems	❑	❑	Physical abuse
❑	❑	Alcohol use	❑	❑	Gender identity	❑	❑	Pregnancy
❑	❑	Anger	❑	❑	Grief	❑	❑	Racing thoughs
❑	❑	Anxiety, nervousness	❑	❑	Guilt	❑	❑	Relational problems
❑	❑	Attention, concentration	❑	❑	Headaches, other pains	❑	❑	Self-esteem
❑	❑	Bad Dreams	❑	❑	Health concerns	❑	❑	Sexual abuse
❑	❑	Childhood Issues	❑	❑	Hearing voices	❑	❑	Sexual problems
❑	❑	Chronic pain	❑	❑	Impulsive behavior	❑	❑	Sleep problems
❑	❑	Codependence	❑	❑	Indecisiveness	❑	❑	Spiritual apathy
❑	❑	Compulsive behaviors	❑	❑	Inferiority feelings	❑	❑	Stress/tension
❑	❑	Controlled by others	❑	❑	Internet addiction	❑	❑	Suicidal thoughts
❑	❑	Controlling	❑	❑	Lack of discipline	❑	❑	Suspicious
❑	❑	Death of friend of loved one	❑	❑	Lack of motivation	❑	❑	Terminal illness
❑	❑	Delusions (false ideas)	❑	❑	Legal matters	❑	❑	Threats, violence
❑	❑	Depression, low mood	❑	❑	Loneliness	❑	❑	Unwanted memories
❑	❑	Divorce, separation	❑	❑	Loss of control	❑	❑	Verbal abuse
❑	❑	Don't like myself	❑	❑	Low self-esteem	❑	❑	Weight/diet issues
❑	❑	Drug use	❑	❑	Marital problems	❑	❑	Withdrawal/isolating
❑	❑	Eating problems	❑	❑	Memory problems	❑	❑	Work problems, stress
❑	❑	Emotional abuse	❑	❑	Mood swings	❑	❑	Other_____
❑	❑	Failure	❑	❑	Nervousness, tension			
❑	❑	Fatigue, low energy	❑	❑	Obsessive thoughts			

Please use an "X" on the scale below to indicate how distressing your problem(s) are to you.

1	2	3	4	5	6	7	8	9	10
Minimally Distressing				Moderately Distressing					Extremely Distressing

Please describe why you are coming to counseling now *(i.e., What are your issues, problems?)*: _____

_____

_____

What do you hope to gain or change by coming for counseling? _____

_____

Are there any other things that can be helpful for us to know about you? _____

_____

TERMS OF SERVICE

I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of intention to cancel, I will be charged the full fee for service.

Signed: _____ Date: _____