



**INTAKE FORM**

**CONFIDENTIAL**

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

**Contact information:**

Date of birth \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone number (cell): \_\_\_\_\_ (home): \_\_\_\_\_ (work): \_\_\_\_\_

Email address: \_\_\_\_\_

May I leave a voicemail on your cell or home number? (yes or no)

Emergency Contact (name): \_\_\_\_\_ (number): \_\_\_\_\_

**Insurance:**

Policy Provider: \_\_\_\_\_ Policy No. \_\_\_\_\_

Subscriber: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_

How did you hear about our counseling services?

Pre-service slide     Service     Flyer     Guest Services Desk     a Life Group

Website     Friend     or Other?

**Relationship Information:**

Marital status (circle one)

Single/Engaged     Married     Separated     Divorced     Widowed

**Work / Educational History:**

Are you employed?  FT     PT     Unemployed

If unemployed describe current situation: \_\_\_\_\_

What type of work do you do? \_\_\_\_\_

Are you a student? Yes \_\_\_\_ No \_\_\_\_ If yes, where? \_\_\_\_\_

Course of study: \_\_\_\_\_

GED     High School diploma     Bachelor's degree     Master's degree     Doctoral degree

**Current family information:**

List the full names of the all persons living in your home.

Name	Age	Relationship to you
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Present area of Concern:**

What is the primary reason that brings you here today? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long has this been a problem for you? \_\_\_\_\_  
\_\_\_\_\_

What do you hope to accomplish through counseling? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What have you done already to deal with the difficulties? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you received counseling in the past? (yes or no) If yes, briefly discuss the nature, duration and outcome. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What would you identify as your strengths overall? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Spiritual History:**

Briefly describe your spiritual relationship with God (if any): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Physical History:**

Are you presently under the care of a medical doctor? \_\_\_\_\_ Your physician(s) will not be contacted without your written consent.

Are you presently under the care of a psychiatrist? \_\_\_\_\_ If so, please list the name(s) of your physician(s):

Med. doctor \_\_\_\_\_ Phone number \_\_\_\_\_

Psychiatrist \_\_\_\_\_ Phone number \_\_\_\_\_

Are you presently on any medication? \_\_\_\_\_ If so, please list all and frequency:

\_\_\_\_\_  
\_\_\_\_\_

**Emotional Status:**

Are you currently experiencing strong emotions? \_\_\_\_\_ If yes, describe \_\_\_\_\_

\_\_\_\_\_

Do you make decisions based on your emotions \_\_\_\_\_ How well does that work for you?

\_\_\_\_\_  
\_\_\_\_\_

Have you had any thoughts of suicide? \_\_\_\_\_ If so, when \_\_\_\_\_

Do you have any thoughts now? \_\_\_\_\_

Are you experiencing any of the following?

- |                             |                                  |                         |
|-----------------------------|----------------------------------|-------------------------|
| _____ Jealousy              | _____ Financial issues           | _____ Feelings of guilt |
| _____ Abandonment           | _____ Passive aggressive         | _____ Anger/rage        |
| _____ Alcohol/drug abuse    | _____ Intimacy problem           | _____ Shame             |
| _____ Withdrawn             | _____ Affair(s)-emotional/sexual | _____ Phobias           |
| _____ Lack of communication | _____ Compulsive behaviors       | _____ Anxiety           |

- \_\_\_\_\_ Spiritual issues
- \_\_\_\_\_ Conflict avoidance
- \_\_\_\_\_ Depression
- \_\_\_\_\_ Panic attacks
- \_\_\_\_\_ Sexual problems
- \_\_\_\_\_ Nightmares
- \_\_\_\_\_ Mood Instability
- \_\_\_\_\_ Suicidal thoughts
- \_\_\_\_\_ Eating Issues
- \_\_\_\_\_ Uncontrollable fears
- \_\_\_\_\_ Controlling behaviors
- \_\_\_\_\_ Low self-worth

Is there a history of any of the following in your family? Please indicate relation to each one identified (self, mother, father, stepparent, brother, sister, child, grandparent, or other type of guardian, i.e. aunt or uncle).

	<b>Relation</b>	<b>Presently Occurring</b>	<b>Past</b>
Divorce			
Alcohol abuse			
Drug abuse			
Suicide			
Physical abuse			
Eating disorder			
Sexual abuse			
Sexual addiction			
Mental illness			
Chronic physical illness			

**Other:**

Is there anything else that is important for me as your therapist to know, and that you have not written about on any of these forms? If yes, please discuss here:

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# COUNSELING AGREEMENT

As part of the counseling process, I understand that I may be required to follow through with homework exercises such as reading, changing behaviors, praying, or other initiatives that will serve my best interest. Ultimately I understand that I am entirely responsible for my own actions and I will always make my own final decisions regarding counseling. \_\_\_\_\_ Initial

I further understand that my progress will be a direct result of my honesty, the work that I will put into resolving my issues and my willingness to move forward even if it is painful and difficult. \_\_\_\_\_ Initial  
I understand that my communication with my counselor is strictly confidential and will not be released to anyone without my consent, unless I am in violation of codes of abuse – physical or sexual, a harm to myself or others. By law, my counselor is required to report such exceptions to the proper authorities in order to protect myself and/or those in danger. \_\_\_\_\_ Initial

Additionally, my counselor may consult with another therapist regarding my case. This therapist will also be bound by the same confidentiality laws, that being said, my name and identity will remain anonymous. \_\_\_\_\_ Initial

I understand that I will pay in full for each session (**50 minutes**). The rate is \$95/session. I understand that I will pay the **\$95 cancellation fee** for appointments not cancelled with **24 hours** notice. You may notify your therapist by phone to cancel or reschedule. \_\_\_\_\_ Initial (954)755-7767 x105 or (954)282-9648

Finally, although we meet in a church setting, I understand that if I see my counselor outside of the counseling sessions she will not discuss my sessions outside of my scheduled visits. This is protect the boundaries of the counselor/client relationship. \_\_\_\_\_ Initial

I acknowledge that I have read this agreement in its entirety and agree to the conditions set forth.

\_\_\_\_\_ Date \_\_\_\_\_  
(Client or Parent Guardian Signature)

\_\_\_\_\_ Printed Name

\_\_\_\_\_ Printed Name