Counseling Center

Intake Form

The following form, which will become a part of your confidential record, will enable us to gain a quicker understanding of you. Please answer each question as completely and as carefully as you can. Please use the bottom of the last page for any additional information or comments.

Name_____ Date of Birth_____ Age____ Sex_____

Present Address_____Phone_____
Number Street

_____Cell Phone_____
City State Zip Code

_____
Email address

Marital Status: Single_____ Married_____ (# of Years_____) Divorced_____ Separated _____ Widowed_____

Presently Living With: Parents____ Spouse____ Roommate____ Alone____ Other_____

Family Member to notify in case of Emergency:

Name_____Address_____

Phones_____Relationship_____

Occupation: _____Total hours worked per week_____

Employed by:_____ Years of Education: _____Phone_____

Referred by:
_____

Religious Affiliation_____ Pastors Name _____

Active Member_____ Inactive Member_____ Church You Attend _____

Members of Current Household: (living with you in the same house)

Relationship	Name	Age	Last Grade Completed	Occupation

Describe any physical problems you have that require medication or physical care:_____

_____

Are you currently receiving medical treatment? _____ If so, Doctors name: _____

Health Info: _____

Are you currently taking medications?_____ Please list Medications_____

_____

Previous Counseling/Therapy? _____If yes, when?_____

Where & with whom?_____
Name **Title**

_____
Address **Phone**

Please list your parents (living or deceased) and any brothers or sisters:

Relationship	Name	Age	Last Grade in School	Occupation	How often do you see them?

In your own words, briefly describe the main problem which prompted you to seek counseling at this time.

_____

_____

Have there been times when the problem got better or disappeared? Yes _____No_____

If so, when?_____

Were there times when the problem was especially bad? Yes _____No_____

Explain_____

_____

Please list any persons you feel may have played a major role in causing your problems_____

_____

Please list any person who helps you cope with your problems_____

_____

Please check the type of counseling you desire:

Individual____ Pre-marital ____ Marital____ Child/Teen_____ Short Term Crisis _____ Family_____ Addiction ____

Group_____ Divorce Recovery_____ Grief/Loss _____ Illness _____Occult_____ Abuse_____ Domestic Violence_____

Anger Management ____ Stress Management ____ Sexual Issues _____ Emotional Healing _____ Relationships _____

Other_____

Please make a check mark next to each item which identifies an area of concern for you. Place two checks by those items that are most important..

_____Addictions (alcohol, drugs, food, gambling, sex, etc.)

_____Anger

_____Depression

_____Education/Learning Difficulties

_____Eating Difficulties

_____Fearfulness/Anxiety/Panic Attacks

_____Marital Problems

_____Health/Physical Problems

_____Problems with social relationships

_____Financial Problems

_____Mental Health Problems

_____Problems with children

_____Problems with parents

_____Religious/Spiritual Concerns

_____Sexual Concerns

_____Thoughts of Suicide

_____Trouble making Decisions/confusion

_____Unhappy most of the time

_____Addiction of a family member

_____Work/Job related

_____Worry

_____Other (Specify)_____

I, _____(print your name), have read the policy sheet, completed the intake form, and have submitted to counsel of my own free will. I recognize that Cathy Fleenor is a Certified Christian Counselor and may approach me with Christian or Biblical concepts and prayer. I will not hold Cathy Fleenor L.L.C. responsible for the outcome of therapy. (It is my choice to follow the counsel or not). The responsibility for growth and change ultimately rests with me.

_____ _____

Signature **Date**

For clients 17 years and under, the signature of his/her guardian or custodial parent is required.

_____ _____

Signature of Parent or Guardian **Date**

Comments or further information: