**~Real Hope Counseling~**

**Confidential Intake Information**

|  |  |
| --- | --- |
| Name:  | Date:  |
| Date of Birth:  | Relationship Status:  |
| Age: | Gender:   M  / F |
| Complete Mailing Address: |  |
| Home/Cell Phone:  | Is it OK to leave a message for you at this number?  Y / N |
| Work Phone:  | Is it OK to leave a message for you at this number?  Y / N |
| Email:  | Is it OK to email you? Y / N  |
| Names & Ages of Dependents: |   |
| Current Employer: | Position Title:  |
| Current Occupational Status: (i.e., F/T, P/T, self-employed, student, returning to work): |
| Emergency Contact Name:  |  |
| Emergency Contact Relationship: | Emergency Contact Phone: |
| Do you feel confident you will spend eternity with God? Y/N Why? | Do you wish for biblical principles to be a key part of your counseling? Y/N?  |
| How did you hear about Real Hope Counseling? |  |

**Current Concerns:**

What concern(s) brings you to counseling?

When did this concern begin (give dates)?

Please describe significant events occurring at that time, or since then, which may relate to the development or maintenance of this concern:

What steps have you taken so far to address your concern(s)?

What do you see as your greatest need?

What do you hope to accomplish in counseling?

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What would reaching your counseling goals look like to you? How would things be different?

What kind of obstacles could get in the way?

Have you been in therapy before or received any prior professional counseling for your concerns? Y/N

If so, what was helpful in previous counseling?

Were there any things you did *not* find helpful in previous counseling?

Please give approximate year(s) & duration of counseling and what you believe were the results:

**Behavior – circle any of the following behaviors that apply to you in the last month:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Overeat | Suicidal attempts | Can’t keep a job | Take drugs | Compulsions |
| Insomnia | Vomiting | Smoke | Take too many risks | Odd behavior |
| Withdrawal | Lack of motivation | Drink too much | Nervous tics | Eating problems |
| Work too hard | Procrastination | Sleep disturbance | Crying | Impulsive reactions |
| Phobic avoidance | Outbursts of temper | Loss of control | Aggressive behavior | Concentration difficulties |

Are there any specific behaviors, actions, or habits that you would like to change?

**Feelings – circle any of the following feelings that apply to you in the last month:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Angry | Guilty | Unhappy | Annoyed | Happy | Bored | Sad |
| Conflicted | Restless | Depressed | Regretful | Lonely | Anxious | Hopeless |
| Contented | Fearful | Hopeful | Excited | Panicky | Helpless | Optimistic |
| Energetic | Relaxed | Tense | Envious | Jealous | Others: |   |

**Physical – circle any of the following symptoms that apply to you in the last month:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Headaches | Stomach trouble | Skin problems | Dizziness | Tics |
| Dry mouth | Palpitations | Fatigue | Burning or itchy skin | Muscle spasms |
| Twitching | Chest pains | Tension | Back pain | Rapid heart beat |
| Sexual disturbances | Tremors | Unable to relax | Fainting spells | Blackouts |
| Bowel disturbances | Hear things | Excessive sweating | Tingling | Watery eyes |
| Visual disturbances | Numbness | Flushing | Hearing problems | Don’t like being touched |

Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Biological Factors:**

Do you have any current concerns about your physical health? Y/N Please specify:

Please list medicines you are currently taking, or have taken during the past 6 months (include any medicines that were prescribed or taken over the counter):

Do you get regular exercise? Y/N If so, what type and how often?

Do you currently have any thoughts of harming yourself? Y/N

Do you have any thoughts of harming someone else? Y/N

Are you feeling any concerns for safety, in your current living arrangements? Y/N

**Please check any of the following that apply to you:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Never** | **Rarely** | **Frequently** | **Very Often** |  | **Never** | **Rarely** | **Frequently** | **Very Often** |
| Marijuana |   |   |   |   | Heart problems |   |   |   |   |
| Tranquilizers |   |   |   |   | Nausea |   |   |   |   |
| Sedatives |   |   |   |   | Vomiting |   |   |   |   |
| Aspirin |   |   |   |   | Insomnia |   |   |   |   |
| Cocaine |   |   |   |   | Headaches |   |   |   |   |
| Painkillers |   |   |   |   | Backaches |   |   |   |   |
| Alcohol |   |   |   |   | Early morning awakening |   |   |   |   |
| Coffee |   |   |   |   | Fitful sleep |   |   |   |   |
| Cigarettes |   |   |   |   | Sleep apnea |   |   |   |   |
| Narcotics |   |   |   |   | Poor appetite |   |   |   |   |
| Stimulants |   |   |   |   | Binge / Purge |   |   |   |   |
| Hallucinogens |   |   |   |   | Lack of interest in activities  |   |   |   |   |
| Diarrhea |   |   |   |   | Eat “junk foods” |   |   |   |   |
| Compulsive Exercise |   |   |   |   | High blood pressure |   |   |   |   |
| Use Laxatives |   |   |   |   | Allergies |   |   |   |   |

Thank you for taking the time to complete this intake information!

Is there any other information you would like for me to know?

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