Shontel Thomas, Christian Counselor and Life Coach

Restoration Christian Wellness Center (RCWC)

Business Line: (732) 357-2880

CONFIDENTIAL ADULT CLIENT INTAKE FORM

Name: ________________________________ Today's Date: __________________

Sex: □ Male □ Female Date of Birth: ________________ Age:________

Address: ____

Home phone: _______________________ Work phone: _________________________

Cell phone: _________________________

Any number you do not want to be contacted at: ________________________________
Check here if you are a Christian □
Do you regularly attend a church?
□Yes
□No
If yes, which one?

RELATIONAL INFORMATION
Current marital status:
□Single
□Engaged
□Married
□Separated
□Divorced
□Widowed
If engaged, married, separated, divorced, or widowed, for how long? _______

Number of previous marriages for you. _________ For your spouse. _______

If married, spouse's name: _________________________ Age: ____________

Is your spouse supportive of you seeking counseling?
□Yes
□No
□Unsure
□Spouse doesn't know

Please provide a brief description of your spouse (e.g
., angry and controlling; outgoing and supportive):

What is your current occupation?

What is your level of satisfaction with your occupation?

Please list your children (including step, adopted, foster) below:

Name	Sex	Age or yr. of death	Relationship to you

Who else lives with you?

COUNSELING HISTORY
If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, plea se list the names of the therapists or programs
. (Use the back if necessary.)

Therapist's Name or Program	Major Issue	Dates

Has anyone in your family ever been treated or hospitalized for substance abuse, mental health issues, or psychiatric conditions?
□Yes
□No
If yes, please describe: ____

Have any of your family members or friends ever attempted or committed suicide?
□Yes
□No
If yes, who and when: ____

MEDICAL HISTORY
Please list any conditions, illnesses, treatments, or surgeries that might be relevant to your reason for seeking counseling:

Are you currently receiving any medical treatment?
□Yes
□No
If yes, please describe: ________________________

Please list all current medications you are taking and the reasons for taking them. (List even if you seldom use, or take only as needed.)

Date and outcome of last physical exam:

PRESENT ISSUES AND GOALS

Please describe why you are coming to counseling. (i.e. what are your issues, problems, symptoms, how long, etc. Use the back if necessary.):

Check any of the following symptoms or problems that you currently are or recently have experienced:

□Stress
□Marital Problems
□Compulsive Behaviors
□Anxiety
□Other Relational Problems
□Seeing Things Others Don’t
□Panic
□Physical Abuse
□Hearing Voices
□Depression
□Emotional Abuse
□Racing Thoughts
□Apathy
□Verbal Abuse
□Eating Problems
□Fatigue/Lack of Energy
□Sexual Abuse
□Drug Use
□Loss of Appetite/Overeating
□Sexual Problems
□Alcohol Use
□Trouble Sleeping
□Gender Identity Issues
□Pregnancy
□Poor Concentration
□Anger
□Abortion
□Feeling Worthless
□Aggressive Behavior
□Legal Matters
□Recent Death
□Bad Dreams
□Work Stress
□Grief

□Unwanted Memories
□Career Choices
□Chronic Pain
□Loss of Control
□Indecisiveness
□Loneliness
□Impulsive Behavior
□Parenting Problems
□Fears
□Controlling
□Financial Problems
□Shyness
□Controlled by Others
□Spiritual Problems
□Low Self-Esteem
□Obsessive Thoughts
□Other ______________________

Are you currently experiencing any suicidal thoughts?
□Yes
□No
Have you experienced suicidal thoughts in the past?
□Yes
□No
Have you attempted suicide in the past?
□Yes
□No
Are you currently experiencing any violent or homicidal thoughts?
□Yes
□No

What do you hope to gain from this counseling experience?

____
____
____
____
____

____ ________________
Client's Signature **Date**