HIGHER HEIGHTS COUNSELING
INTAKE FORM

IDENTIFICATION INFORMATION:

Name: _____ Phone: _____

Address: _____

Occupation: _____Bus. Phone: _____

Email: _____ May we contact you and/or send personal information to this email? [☐Yes [☐No Sex: [☐Male [☐Female Birth date _____Age: _____

Marital Status: [☐Married [☐Single [☐Widowed [☐Divorced [☐Separated [☐Divorce Filed

Education: (last year completed): _____ Currently attending school / college? [☐Yes [☐No

If yes, pursuing degree in:_____ Expected completion date:_____

Other Training: (list type and number of years): _____

Referred to counseling by: _____

Emergency Contact: _____ _____ _____

Name Phone Number Relationship

HEALTH INFORMATION:

Rate your health: [☐ Very Good |☐ Good [☐Average ☐ Declining

[☐ Other (explain): _____

Recent changes in weight: |☐ Lost |☐ Gained How much: _____

List all important present or past illnesses or injuries or handicaps:

_____

_____

Date of last medical examination: _____ Report Results: _____

Your doctor(s) name: _____ Phone: _____

Doctor's Address: _____

Are you presently taking medication? ☐ Yes |☐ No

If yes, what medication do you take and for what purpose:

Medicine: _____ Purpose: _____

_____ _____

_____ _____

Have you used drugs for other than medical purposes? ☐| Yes ☐ No

If yes, what drugs and purpose:

Drug: _____ Purpose: _____

_____ _____

Daily ☐ Weekly ☐ Monthly ☐ Infrequent ☐

Have you ever had a life changing, stress event or severe emotional upset with the last two years? |☐ Yes ☐ No If yes, explain: _____

_____

_____

If necessary, are you willing to sign a release of information form for your social, mental, or medical records? |☐ Yes ☐| No

COGNITIVE ORIENTATION:

Do you believe in God? ☐ Yes |☐ No |☐ Not sure

Do you consider yourself a religious person? ☐ Yes ☐ No |☐ Not sure

Briefly explain the foundation for your belief system _____

_____

_____

_____

Have you ever felt people were watching you? ☐ Yes ☐ No
Do people's faces ever seem distorted? ☐ Yes ☐ No
Do you ever have difficulty distinguishing faces? ☐ Yes ☐ No
Are you sometimes unable to judge distances? ☐ Yes ☐ No
Do you now or have ever heard voices? ☐ Yes ☐ No
Have you ever had hallucinations (nightmares, etc.) ☐ Yes ☐ No
Is your hearing exceptionally good? ☐ Yes ☐ No
Do you have problems sleeping? ☐ Yes ☐ No
How many hours of sleep do you get per night? _____
Do you now or ever had suicidal thoughts ☐ Yes ☐ No
If yes, when did they begin? _____ How often? _____
Have you ever attempted suicide? ☐ Yes ☐ No If yes, when _____

PERSONALITY:

Have you ever had any psychotherapy or counseling before? ☐ Yes ☐ No

If yes, list the counselor or therapists name and dates of counseling:

Counselor/Agency	Dates of Counseling	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle any of the following words that best describe you now:

Active Ambitious Self-Confident Persistent Nervous Good-Natured Angry Shy
Hardworking Impatient Impulsive Moody Often-Blue Calm Excitable Imaginative
Easy-Going Submissive Leader Self-Conscious Frustrated Lonely Sensitive Serious
Introvert Extrovert Hard-Boiled Likeable Quiet Withdrawn Controlling Other: _____

PERTINENT INFORMATION:

What are your current living arrangements? Parent(s) _____ Alone _____ Roommate _____
Significant Other _____ Other _____

Are you satisfied with this current arrangment? ☐ Yes ☐ No If no, what are your plans for a change:_____

_____

Do you have any broken relationships? ☐ Yes ☐ No If yes, briefly explain: _____

_____

Do you have any lingering regrets? ☐ Yes ☐ No If yes, briefly explain: _____

_____

Do you feel good about the direction your life is headed? ☐ Yes ☐ No If no, briefly explain: _____

_____

Do you feel good about yourself? ☐ Yes ☐ No If no, briefly explain: _____

_____

Are you struggling with your identity or purpose in life? ☐ Yes ☐ No If so, briefly explain: _____

_____

_____

If you were raised by anyone other than your own parents, briefly explain:

_____

_____

How many older siblings? Brothers? _____ Sisters? _____

How many younger siblings? Brothers? _____ Sisters? _____

Is there anything else that we should know about your family?

_____

_____

Do you have children: ☐ Yes ☐| No

Information about children:

NAME	AGE	SEX	LIVING? YES	NO	EDUCATION Level	Indicate if the child adds to or deplete the positive energy in your home or family construct

Is there anything else that we should know about your children?

_____

_____

_____

_____

CURRENT EVENT INFORMATION:

What recent event prompted you to seek counseling?

_____

_____

Are you currently experiencing overwhelming sadness, grief or depression? ☐ Yes ☐ No

If yes, for how long? _____ Briefly explained: _____

_____

_____

Are you currently experiencing anxiety, panic attacks, or have phobias? ☐ Yes ☐ No
If yes, for how long? _____ Briefly explained: _____

_____

_____

Are you currently experiencing any chronic pain? ☐ Yes ☐ No
If yes, for how long? _____ Please describe: _____

_____

_____

Do you drink alcohol more than once a week? ☐ Yes ☐ No If yes, how frequent? _____

Daily ☐ Weekly ☐ Monthly ☐ Infrequent ☐

What would you like to accomplish out of your time in therapy?

_____

_____

_____

What counseling framework do you prefer?

Clinical ☐ Biblical ☐ Integration ☐ Spiritual ☐ Other ☐ Please Specify,

_____

_____

Submit Reset Form