Intake Application

Please note that evening counseling sessions are offered Monday, Wednesday and Friday evenings between 4pm and 8pm.

Please answer the following questions to the best of your ability.

Full Name: _____ Age: _____ Birth Date:
☐Male ☐Female Phone: _____ Can we leave a message? ☐Yes ☐No

Email: _____ Preferred contact method: ☐Phone ☐Email

Address: _____

EMERGENCY CONTACT

Emergency Contact Name: _____ Phone: _____

Relationship to you: _____

ETHNICITY

☐African/African American ☐Asian ☐Hispanic ☐Native American ☐Pacific Islander ☐White

☐Other: _____ ☐ Prefer not to answer

EDUCATION LEVEL COMPLETED

☐High School
Last Grade Completed: _____
☐GED
☐Community College
☐Vocational School/Training
☐Some college
☐Four-Year Degree, Major: _____
☐Graduate Degree: _____
☐Post-Graduate: _____

CURRENT EMPLOYMENT STATUS

☐Full-Time
☐Part-Time
☐Self-employed
☐Retired
☐Unemployed
☐Disability Assistance
☐Work from Home
☐At Home Parent

MARITAL STATUS

☐Single ☐Domestic Partner ☐Married ☐Separated ☐Divorced ☐Remarried ☐Widowed

NUMBER OF CHILDREN: _____ Ages: _____/_____/_____/_____/_____/_____

Who recommended you seek counseling?

☐Self-Referred ☐Spouse ☐Family Member ☐Friend ☐Physician ☐Other: _____

What is the main issue you are seeking counseling for? _____

_____

_____

How long have you had symptoms/problems related to the current issue? _____

What has prompted you to seek help at this time? _____

_____

_____

What areas of your life are affected by your symptoms/problem? Check all that apply:

☐ Work
☐ School
☐ Marital/Significant Other Relationship
☐ Other Close Relationships
☐ Personal Hygiene
☐ Household Duties
☐ Social/Leisure Activities
☐ Other: _____

Have you been diagnosed with any of the following? Check all that apply:

☐ Addiction of any kind (e.g. gambling, sexual, pornography, alcohol, street or prescription drugs/chemicals) Please specify: _____
☐ Anxiety Disorder
☐ Autism Spectrum Disorder
☐ Bipolar Disorder
☐ Depression
☐ Eating Disorder
☐ Impulse Control Disorder
☐ Learning Disorder
☐ Obsessive Compulsive Disorder
☐ Panic Attacks
☐ Personality Disorder
☐ Post-Traumatic Stress Disorder
☐ Schizophrenia
☐ Sleep Disorder
☐ Sexual Disorder
☐ Substance Abuse
☐ Thinking/Memory Disorder
☐ Other: _____

Are you CURRENTLY receiving treatment or care for any mental or emotional conditions EXCLUDING addiction? ☐No ☐Yes - Care provider's name and facility: _____

Have you PREVIOUSLY received treatment for any mental or emotional conditions EXCLUDING addiction? ☐No ☐Yes - Please provide the information on the next page:

Facility or Care Provider	Inpatient or Outpatient	Admission & Discharge Dates	Diagnosis	Discharged with the provider's approval?
				☐Yes ☐No
				☐Yes ☐No

Are you CURRENTLY receiving treatment or care for any type of addiction?

☐No ☐Yes - Care provider's name and facility: _____

Have you PREVIOUSLY received treatment for any type of addiction?

☐No ☐Yes - Please provide the information below:

Facility or Care Provider	Inpatient or Outpatient	Admission & Discharge Dates	Diagnosis	Discharged with the provider's approval?
				☐Yes ☐No
				☐Yes ☐No

Have you maintained sobriety or abstinence from addictive behavior?

☐Yes - How long have you maintained your sobriety? _____

What do you do to maintain your sobriety/abstinence? _____

☐No - What prevents you from maintaining sobriety/abstinence? _____

_____

Are you taking any medications? ☐No ☐Yes - Please List:

Medication	Dose

Are you involved in any current legal issues? ☐No ☒Yes Please specify: _____

_____

What symptoms/problems are you CURRENTLY or HAVE experienced in the past? Check all that apply.

Chronic Physical Illness
- ☐ Cancer
- ☐ Traumatic Head Injury
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Seizure Disorder
- ☐ Thyroid Disease
- ☐ Other: _____

Physical Symptoms
- ☐ Chest Pains
- ☐ Headaches
- ☐ Nausea
- ☐ Weight Gain/Loss of more than 10 pounds in the last 6 months
- ☐ Other: _____

Frequent Pain
- ☐ Abdominal Pain
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Migraines
- ☐ Other: _____

Lack/Loss Of . . .
- ☐ Ambition/Motivation
- ☐ Concentration or Memory
- ☐ Joy/Pleasure
- ☐ Family Member/Friend
- ☐ Spiritual Connection/ Relationship with God

Sleep Disturbances
- ☐ Difficulty Falling Asleep
- ☐ Frequent Awakening
- ☐ Sleep Too Little - Number of Hours: _____
- ☐ Sleep Too Much -
- ☐ Number of Hours: _____
- ☐ Obstructive Sleep Apnea
- ☐ Other: _____

Abuse
- ☐ Emotional
- ☐ Physical
- ☐ Sexual
- ☐ Spiritual

Convictions
- ☐ Misdemeanor
- ☐ Felony
- ☐ Other: _____

Life Transition
- ☐ Adoption
- ☐ Career/Job Change
- ☐ Unemployment
- ☐ Elderly Parents
- ☐ Empty Nest
- ☐ Graduation
- ☐ New Child
- ☐ Retirement
- ☐ Single Parent
- ☐ Other: _____

Pregnancy issues
- ☐ Infertility
- ☐ Loss of Pregnancy
- ☐ Teenage Pregnancy
- ☐ Termination (Post Termination Issues)
- ☐ Unplanned Pregnancy
- ☐ Other: _____

Relationship Issues
- ☐ Friends
- ☐ Supervisor/Teacher
- ☐ Work Environment
- ☐ Parents
- ☐ Spouse/Partner
- ☐ Separation
- ☐ Divorce
- ☐ Infidelity
- ☐ Children
- ☐ Teenagers
- ☐ Blended Family
- ☐ Other: _____

Sexual Difficulties/Issues
- ☐ Erectile Dysfunction
- ☐ Gender Identity
- ☐ Loss of Interest
- ☐ Pornography
- ☐ Promiscuity
- ☐ Unfaithfulness
- ☐ Other: _____

Addictive Behavior
- ☐ Alcohol
- ☐ Cigarettes
- ☐ Illegal Drugs
- ☐ Prescription Drugs
- ☐ Marijuana
- ☐ Gambling
- ☐ Pornography
- ☐ Sexual
- ☐ Other: _____

Anxiety and/or Panic
- ☐ Panic Attacks
- ☐ Social Anxiety
- ☐ Fears/Phobias
- ☐ Intrusive Thoughts
- ☐ Checking
- ☐ Hand Washing
- ☐ Hoarding
- ☐ Disturbing Habits
- ☐ Other: _____

Eating Issues
- ☐ Anorexia
- ☐ Bulimia
- ☐ Compulsive Eating
- ☐ Overeating
- ☐ Binging

Loss of Appetite

Military Service
- ☐ Combat
- ☐ Combat Injury

Other
- ☐ Anger
- ☐ Grief
- ☐ Mood Changes
- ☐ Self-Esteem
- ☐ Perfectionism
- ☐ Financial Problems
- ☐ Flashbacks to Trauma
- ☐ Disturbing Thoughts (hearing or seeing things that others do not)
- ☐ Loneliness/Sadness
- ☐ Suicidal Thoughts
- ☐ Homicidal Thoughts
- ☐ Other: _____

Do you feel safe in your home? ☐Yes ☐No

For the following questions/statements, circle the number that most closely fits you:

How important are spiritual/faith issues in counseling?

Not at all important — Somewhat Important — Very important

1 —— 2 —— 3 —— 4 —— 5

How important is prayer?

Not at all important — Somewhat Important — Very important

1 —— 2 —— 3 —— 4 —— 5

My life is filled with meaning.

Disagree — Neutral — Strongly Agree

1 —— 2 —— 3 —— 4 —— 5

I have hope for the future.

Disagree — Neutral — Strongly Agree

1 —— 2 —— 3 —— 4 —— 5

I find meaning in relationships with others.

Disagree — Neutral — Strongly Agree

1 —— 2 —— 3 —— 4 —— 5

I find meaning in artistic or musical pursuits.

Disagree — Neutral — Strongly Agree

1 —— 2 —— 3 —— 4 —— 5

I find meaning in physical or sport pursuits.

Disagree — Neutral — Strongly Agree

1 —— 2 —— 3 —— 4 —— 5

Do you have specific faith beliefs? Check all that apply:

- ☐ Agnostic
- ☐ Atheist
- ☐ Buddhism
- ☐ Christianity, please specify denomination: _____
- ☐ Hinduism
- ☐ Islam
- ☐ Judaism
- ☐ Not sure
- ☐ Occult, please specify: _____
- ☐ Other, please specify: _____

Are you involved in a faith community or place of worship? ☐Yes ☐No

Are you satisfied with your spiritual growth? ☐Yes ☐No

Is there anything else that you want your counselor to know?

_____

_____

_____

Have you submitted an intake form to The Compassion Clinic Counseling Resource Center before?
☐Yes ☐No
If yes, and your name has changed, please provide your former name: _____

How did you hear about the The Compassion Clinic Counseling Resource Center?
☐Brochure ☐Church ☐Friend ☐Internet ☐Newsletter ☐Other: _____

APPOINTMENT PREFERENCES Appointments are **weekly on Monday, Wednesday or Friday evenings.**

Time Preference:

☐ 4:00PM
☐ 5:00PM
☐ 6:00PM
☐ 7:00PM
☐ 8:00PM

Counselor Preference:

☐ Male Counselor Requested
☐ Female Counselor Requested
☐ No Preference

Every effort will be made to honor your preferences. Please call 434-429-8813 *if you have questions.*

The Compassion Clinic Counseling Resource Center (TCCCRC) has provided Christian lay counseling care since 2010. I understand that care is guided by Christian principles to heal and help people with the unconditional love of Jesus. I consent to counseling and care at The Compassion Clinic Counseling Resource Center. Signature: _____ Date: _____

Please upload and email the completed application to:
The Compassion Clinic Counseling Resource Center
compassionclinicresources@gmail.com

Privacy Disclosure: The Compassion Clinic Counseling Resource Center promises to the applicant that the information provided in this document will be kept strictly confidential. No information will be sold or given to any individual or company. No information on this application will be shared with anyone other than essential TCCCRC staff and counselors without your written consent.