Confidential Client Intake Form

MARIE CARTER & ASSOCIATES
Pastoral Counseling Services

GENERAL INFORMATION

Last Name________________________ First ________________ Middle Initial ____________

Preferred Name ____________________ Birth Date: / / Male ______ Female __________

Street Address ____ Apt # __________

City _____________________________ State _____________________ Zip __________

Home Phone ( ) _______________ Work Phone ( ) ____________ Other ( ) ____________

Any phone instructions (re: msgs, etc) ____

Email #1: ______________________________ Email #2: ______________________________

Emergency Contact _______________ Phone ( ) __________________ Relationship __________

Parent/Guardian (if under 18) ____

Referred by/How you learned of mc and assoc.: ____________________________________

Reason for referral: ____

Reason for choosing mc and assoc.: ____

Religious/Denominational preference: ____

Your church/synagogue: ___________________________________ Member? _______________

Pastor/Priest/Rabbi: ____

Attendance: Regular _________ Occasional _________ Seldom _________ Never _________

FAMILY INFORMATION

Relationships: Single ___ Engaged ___ Married ___ Separated ___ Divorced ___ Widow(er) ___ Cohabiting ___

Parents: Mother: Living ___, age ____. Deceased ___. Father: Living ___, age ____. Deceased ___

Siblings: Number of Brothers [ ]. Number of Sisters [ ]. Only Child ____.

Names and ages of your children: ____

____

____ Have any of your children died? _________

Household members not listed above ____

____

EMPLOYMENT/EDUCATION INFORMATION

Full time employee ____ Full time at home ____ Part-time employee ____ Unemployed ____

Place of employment _________________________________ Length of Employment ___________

Type of work you do ____

Highest level of education completed: High School _________ College degree _________ Graduate degree _________

Professional Training _______________ Other ____

What is your gross (before taxes) combined household annual income? ____________________

____

(Over)

What are your concerns/problems that cause you to seek counseling at this time?

____

____

____

Check the following words that describe you at this time:

____ Anger
____ Anxiety
____ Chronic fear
____ Conflicts at work
____ Depression
____ Financial Problems
____ Grief
____ Guilt feelings
____ Health Issues
____ Irrational fears
____ Loneliness
____ Loss of faith in God
____ Loss of hope
____ Loss of meaning in life
____ Loss of work/job
____ Marriage problems
____ Nervousness
____ Rage
____ Relationship to parents
____ Relationship to children
____ Self-esteem
____ Sexual Problems
____ Stress
____ Substance abuse
____ Suicidal feelings
____ Religious doubts
____ Other (list)

____

____

____

What are you hoping to achieve with counseling?____

____

MEDICAL/PSYCHOLOGICAL HISTORY

Name of your physician:_____________________________________Phone: (   )________________

When was your last medical examination? ____

Are you suffering any physical illnesses or symptoms at this time? ______________________________

List major surgeries or illnesses in the last five years: ____

____

List current medications: ____

____

Are there chemical abuse issues in your family? Yes ____ No ____ If clean/sober, for what length of time? __________

When? ____________________ Name of helping agency: ___________________________________

Have you received psychotherapy or counseling in the past year? Yes ____ No ____ When? __________________

Name of treating therapist: ____________________________ Where? ____________________________

Type of problem: ____

Make a check mark if you would answer “yes” to any of these questions:

___ Do you have thoughts of harming yourself or others?

___ Are thoughts of harming yourself or others a frequent occurrence?

___ Do you dwell on these thoughts and wonder if you can control them?

___ Have you sought professional help because of these thoughts or feelings?

PAYMENT METHOD

Party responsible for payment, if other than client: Name: ___________________________________

Address: __________________________ Phone: (   )________________ Agreed hourly fee $__________

____ ____________________

Client’s Signature Date

____ ____________________

Therapist’s Signature Date