INTAKE FORM

Full Name: _____ Text _____

Date of Birth: ___ /____ /____ Age: _____

Cell Phone: _____

Home Phone: _____

Work Phone: _____

Email: _____

May I leave you a message? ❑ Cell Phone ❑ Home Phone ❑ Work Phone

May I contact you by email? ❑ Yes ❑ No

Street Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Marital Status:

❑ Single ❑ Dating ❑ Engaged ❑ Married ❑ Remarried
❑ Separated ❑ Divorced ❑ Widowed ❑ Cohabitating

Has your spouse been previously married? ❑ Yes ❑ No
If yes, how many times? _____

Church Membership: ❑ Member ❑ Membership in Process ❑ Regular Attendee ❑ Visitor

Spouse:

Full Name: _____

Date of Birth: ___ /____ /____ Age: _____

Cell Phone: _____

Home Phone: _____

Work Phone: _____

Email: _____

Employer: _____ Occupation: _____

May I leave you a message? ❑ Cell Phone ❑ Home Phone ❑ Work Phone

May I contact you by email? ❑ Yes ❑ No

List all children (living with you or not) and any other people living with you:

Name	Relation	Date of Birth	Living With You

Briefly describe your reason for seeking help: _____

When did a physician last examine you? _____

Physician's Name: _____ Phone Number: _____

List current and past medical conditions for which you have received treatment:

Condition	Date

List current medications and dosage:

Medication	Dosage

Have you (or your spouse) ever been involved in any type of counseling? ❑ Yes ❑ No

Date	Therapist/Counselor	Reason

Have you ever been hospitalized for a psychological disorder? ❑ Yes ❑ No

If yes,

Reason	Date

Legal History (Criminal and/or Civil)

Please mark all the symptoms that apply to **YOU**:

CURRENT PAST

- ❑❑ Depressed Mood
- ❑❑ Persistent Sadness
- ❑❑ Crying Spells
- ❑❑ Inability to Enjoy Things
- ❑❑ Increased Appetite
- ❑❑ Excessive Weight Gain
- ❑❑ Excessive Weight Loss
- ❑❑ Increased Sleep
- ❑❑ Decreased Sleep
- ❑❑ Irritability or Anger
- ❑❑ Loss of Motivation
- ❑❑ Fatigue, Loss of Energy
- ❑❑ Feelings of Worthlessness
- ❑❑ Inappropriate Guilt
- ❑❑ Difficulty Concentrating
- ❑❑ Preoccupation with Death
- ❑❑ Pessimism
- ❑❑ Hopelessness
- ❑❑ Poor Memory
- ❑❑ Self-Destructive Acts
- ❑❑ Self-Destructive Thoughts

CURRENT PAST

- ❑❑ Suicidal Thoughts
- ❑❑ Suicidal Attempts
- ❑❑ Elevated Mood
- ❑❑ Grandiosity
- ❑❑ Decreased Need for Sleep
- ❑❑ Racing Thoughts
- ❑❑ Mood Swings
- ❑❑ Pressured Speech or Increased Talking
- ❑❑ Distractibility
- ❑❑ Increased Goal-Directed Activity
- ❑❑ Extreme Involvement in Pleasurable Activity with Potential Painful or Negative Consequences
- ❑❑ Agitation
- ❑❑ Alcohol Use
- ❑❑ Alcohol Abuse
- ❑❑ Compulsive Dieting
- ❑❑ Vomiting
- ❑❑ Blackouts
- ❑❑ Sexual Difficulties

CURRENT PAST

- ❑❑ Self-Harm Behaviors *(cutting, hair-pulling, burning, etc.)*
- ❑❑ Drug Use
- ❑❑ Panic *(racing heart, chest pain, shortness of breath, numbness, dizziness, sweating, fear of dying)*
- ❑❑ Fear of Leaving Home
- ❑❑ Social Anxiety
- ❑❑ Phobias
- ❑❑ Recurrent Undesirable images, thoughts, or impulses
- ❑❑ Repetitive Behavior *(or mental acts that are irresistible)*
- ❑❑ Excessive or Uncontrollable Worry
- ❑❑ See or Hear Things That Are Not There
- ❑❑ Strange Thought Patterns
- ❑❑ Paranoia
- ❑❑ Strange Experiences
- ❑❑ Pornography Use

Please mark all the symptoms that apply to your **SPOUSE/OTHER**:

CURRENT PAST

- ❑❑ Depressed Mood
- ❑❑ Persistent Sadness
- ❑❑ Crying Spells
- ❑❑ Inability to Enjoy Things
- ❑❑ Increased Appetite
- ❑❑ Excessive Weight Gain
- ❑❑ Excessive Weight Loss
- ❑❑ Increased Sleep
- ❑❑ Decreased Sleep
- ❑❑ Irritability or Anger
- ❑❑ Loss of Motivation
- ❑❑ Fatigue, Loss of Energy
- ❑❑ Feelings of Worthlessness
- ❑❑ Inappropriate Guilt
- ❑❑ Difficulty Concentrating
- ❑❑ Preoccupation with Death
- ❑❑ Pessimism
- ❑❑ Hopelessness
- ❑❑ Poor Memory
- ❑❑ Self-Destructive Acts
- ❑❑ Self-Destructive Thoughts
- ❑❑ Suicidal Thoughts

CURRENT PAST

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- ❑❑ Agitation
- ❑❑ Alcohol Use
- ❑❑ Alcohol Abuse
- ❑❑ Compulsive Dieting
- ❑❑ Vomiting
- ❑❑ Blackouts
- ❑❑ Sexual Difficulties

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- ❑❑ Strange Experiences
- ❑❑ Pornography Use

Person to contact in case of an emergency: _____

Relationship: _____

Phone Number(s): _____

This person will only be contacted in case of an emergency.

Signature: _____ Date: ___ /___ /___

Spouse's Signature (Marital Counseling): _____ Date: ___ /___ /___