## **INTAKE FORM**

| INTAKE FORIVI  |                   |                   |                 |
|--|-------------------|-------------------|-----------------|
| Full Name: Text  |                   |                   |                 |
| Date of Birth: / Age:  |                   |                   |                 |
| Cell Phone:  |                   |                   |                 |
| Home Phone:  |                   |                   |                 |
| Work Phone:  |                   |                   |                 |
| Email:   |                   |                   |                 |
| May I leave you a message? ☐ Cell Phone  | ☐ Home Phone      | e 🔲 Work Phon     | ne              |
| May I contact you by email? ☐ Yes ☐ No   |                   |                   |                 |
| Street Address:  |                   |                   |                 |
| City:  |                   |                   |                 |
| Employer:  | Оссир             | oation:           |                 |
| Marital Status: ☐ Single ☐ Dating ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Col |                   |                   |                 |
| a deparated a pivorced a widowed a doi   | labitatilig       |                   |                 |
| Has your spouse been previously married? ☐ `If yes, how many times?                          | Yes □ No          |                   |                 |
| Church Membership: ☐ Member ☐ Members  | hip in Process    | ☐ Regular Attende | e 🗖 Visitor     |
| Spouse:  |                   |                   |                 |
| Full Name:   |                   |                   |                 |
| Date of Birth: / Age:  |                   |                   |                 |
| Cell Phone:  |                   |                   |                 |
| Home Phone:  |                   |                   |                 |
| Work Phone:  |                   |                   |                 |
| Email:   |                   |                   |                 |
| Employer:  | Occup             | oation:           |                 |
| May Lleave you a massage? ☐ Call Phone. ☐  | Hama Dhana 🗆      | Work Phone        |                 |
| May I leave you a message? □ Cell Phone □ May I contact you by email? □ Yes □ No             | Home Phone L      | Work Phone        |                 |
| List all children (living with you or not) and ar  | ny other people l | iving with you:   |                 |
| Name   | Relation          | Date of Birth     | Living With You |
|  |                   |                   |                 |

| Name | Relation | Date of Birth | Living With You |
|------|----------|---------------|-----------------|
|      |          |               |                 |
|      |          |               |                 |
|      |          |               |                 |
|      |          |               |                 |
|      |          |               |                 |

| Briefly describe your reason for seeking help: |                               |                              |            |
|--|-------------------------------|------------------------------|------------|
|  |                               |                              |            |
|  |                               |                              |            |
|  |                               |                              |            |
|  |                               |                              |            |
|  |                               |                              |            |
|  |                               |                              |            |
| When did a phys                                | sician last examine you?      |                              |            |
|  | e:                            |                              | nber:      |
|  |                               |                              |            |
| List current and                               | past medical conditions for w | rhich you have received trea | tment:     |
|  | Condition                     |                              | Date       |
|  |                               |                              |            |
|  |                               |                              |            |
|  |                               |                              |            |
|  |                               |                              |            |
|  |                               |                              |            |
|  |                               |                              |            |
| List current med                               | lications and dosage:         |                              |            |
|  | Medication                    |                              | Dosage     |
|  |                               |                              |            |
|  |                               |                              |            |
|  |                               |                              |            |
|  |                               |                              |            |
|  |                               |                              |            |
|  |                               |                              |            |
| Have you (or you                               | r spouse) ever been involved  | in any type of counseling? 🛭 | ☐ Yes ☐ No |
| Date   | Therapist/Counselor           | Re                           | ason       |
|  |                               |                              |            |
|  |                               |                              |            |
|  |                               |                              |            |
|  |                               |                              |            |

|                                    | Reason   | Date  |
|------------------------------------|--|---|
|                                    |  |   |
|                                    |  |   |
|                                    |  |   |
|                                    | Legal History (Criminal and/or Civ                 | :1)   |
|                                    | Legal History (Chillinal and/or Civ                | 11)   |
|                                    |  |   |
|                                    |  |   |
|                                    |  |   |
|                                    |  |   |
| Please mark all the symptoms       |  | 4   |
| JR <sup>EDI</sup>                  | CIRRENT  | CHERT   |
| Depressed Mood                     | □□ Suicidal Thoughts                               | □□ Self-Harm Behaviors                                  |
| Persistent Sadness                 | □□ Suicidal Attempts                               | (cutting, hair-pulling,<br>burning, etc.)               |
| ☐ Crying Spells                    | □□ Elevated Mood                                   | □□ Drug Use   |
| ☐ Inability to Enjoy Things        | □ Grandiosity                                      | □□ Panic  |
| ☐ Increased Appetite               | □□ Decreased Need for Sleep                        | (racing heart, chest pain,                              |
| <b>□</b> Excessive Weight Gain     | □□ Racing Thoughts                                 | shortness of breath, numbness dizziness, sweating, fear |
| ■ Excessive Weight Loss            | □□ Mood Swings                                     | of dying)   |
| ☐ Increased Sleep                  | □□ Pressured Speech or                             | ☐☐ Fear of Leaving Home                                 |
| <b>□</b> Decreased Sleep           | Increased Talking                                  | □□ Social Anxiety                                       |
| ☐ Irritability or Anger            | □□ Distractibility                                 | □□ Phobias  |
| ■ Loss of Motivation               | □□ Increased Goal-Directed<br>Activity             | ☐☐ Recurrent Undesirable images, thoughts, or           |
| ☐ Fatigue, Loss of Energy          | □□ Extreme Involvement in                          | impulses  |
| <b>□</b> Feelings of Worthlessness | Pleasurable Activity                               | □□ Repetitive Behavior (or mental acts that             |
| Inappropriate Guilt                | with Potential Painful or<br>Negative Consequences | are irresistible)                                       |
| ☐ Difficulty Concentrating         | □ Agitation  | □□ Excessive or   |
| ☐ Preoccupation with Death         |  | Uncontrollable Worry                                    |
| <b>□</b> Pessimism                 | □□ Alcohol Abuse                                   | ☐☐☐ See or Hear Things That<br>Are Not There            |
| <b>□</b> Hopelessness              | □□ Compulsive Dieting                              | □□ Strange Thought Patterns                             |
| ☐ Poor Memory                      | □□ Vomiting  | □ Paranoia  |
| ■ Self-Destructive Acts            | □□ Volliting □□ Blackouts                          | ☐☐ Strange Experiences                                  |
| ■ Self-Destructive Thoughts        |  | □ Pornography Use                                       |

| Please mark all the symptoms the  | nat apply to your <b>SPOUSE/OTHE</b>   | iR:   |
|---|--|---|
| Depressed Mood Depressed Mood Crying Spells Inability to Enjoy Things Increased Appetite Excessive Weight Gain Excessive Weight Loss Increased Sleep Decreased Sleep Irritability or Anger  | nat apply to your SPOUSE/OTHE  Suicidal Attempts  Suicidal Attempts  Elevated Mood  Grandiosity  Decreased Need for Sleep  Racing Thoughts  Mood Swings  Pressured Speech or Increased Talking  Distractibility  Increased Goal-Directed | 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 |
| □□ 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 | Activity  Extreme Involvement in Pleasurable Activity with Potential Painful or Negative Consequences  Agitation Alcohol Use Alcohol Abuse Compulsive Dieting Vomiting Blackouts Sexual Difficulties                                     | 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   |
| Relationship:Phone Number(s):   |  |   |
| Signature:  |  | Date: / /   |
| Spouse's Signature (Marital Counse  | eling):  | Date:/  |