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 ☐ Widowed ☐ Separated ☐ Divorced ☐ 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: _____

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: _____

_____

_____

Are you willing to sign a release of information form so that your counselor may obtain your social, psychiatric, or medical reports? ☐ 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 _____

_____

_____

_____

Do you have problems sleeping? ☐ Yes ☐ No

How many hours of sleep do you get per night? _____

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Calm Excitable Imaginative Quiet Likeable Easy-Going Submissive Leader Self-Conscious Introvert Extrovert Hard-Boiled Withdrawn Lonely Sensitive Controlling Serious Shy Frustrated Other: _____

MARITAL INFORMATION:

Name of spouse: _____Phone: _____

Address: _____

Occupation: _____ Bus. Phone: _____

Your spouse's age: _____ Religious Belief: _____

Date of marriage: _____ Age when married: Husband: _____ Wife: _____

How long did you know your spouse before marriage? _____ Length of engagement?_____

How would rate your marriage of a scale 1-10, 10 being above average: _____ Briefly explain your response_____

Is your spouse supportive? ☐ Yes ☐ No If no, how does it impact you:_____

_____

Do you feel Love / Respected by your spouse? ☐ Yes ☐ No If no, briefly explain: _____

_____

Do you and your spouse have a good or working financial practice? ☐ Yes ☐ No If no, briefly explain:

_____

Are your intimate /emotional needs fulfilled? ☐ Yes ☐ No If no, briefly explain:_____

_____

Have you ever been separated? ☐ Yes ☐ No Have either of you filed for divorce? ☐ Yes ☐ No

Is there any other pertinent information about you marriage that you believe will be helpful for me to know, if so please explain?_____

_____

Is your spouse willing to come to counseling? ☐ Yes ☐ No If no, briefly explain why:_____

_____

PREVIOUS MARRIAGE

Is this your first marriage? ☐ Yes ☐ No If no, what number is this marriage? _____

How did your previous marriage end? Divorce _____ Widow/widower _____

How long were you married? _____ What was the contributing factor(s) to your divorce _____

_____

_____

CHILDREN & FAMILY

Do you have children: ☐ **Yes** ☐ **No**

If no, do you want children ☐ Yes ☐ No **If yes**, do you more children ☐ Yes ☐ No

Information about children:

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

*PM = Check this column if child is from a prior marriage or relationship

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

_____

_____

FAMILY INFORMATION

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

_____

_____

How many older siblings? Brothers? _____ Sisters? _____ All living? ☐ Yes ☐ No

How many younger siblings? Brothers? _____ Sisters? _____ All living ? ☐ Yes ☐ No

FAMILY INFORMATION (cont.)

Family Dynamics	Your childhood relationship was: Good, Bad, Nonexistent, Up & down, Other	Your Adult Relationship is: Good, Bad, Nonexistent, Up & down, Other	Living Yes or No	Transitioned Date
Mom				
Dad				
Siblings				
Siblings				
Siblings				
Siblings				
Other				

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

_____

_____

OTHER PERTINENT INFORMATION:

Spouses Income: ☐ $10k -$30k, ☐ $30k-$50k, ☐ $50k-$70k, ☐ $70k-up

Your Income: ☐ $10k -$30k, ☐ $30k-$50k, ☐ $50k-$70k, ☐ $70k-up

Are you content or satisfied with your place of work? ☐ Yes ☐ No ☐ N/A

What is you ideal job/employment? _____

Have you considered making a change in your employment/career? ☐ Yes ☐ If so, what would it take to do so?_____

Do you believe it's obtainable in the near future? ☐ Yes ☐ No If not, why _____

_____

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: _____

_____

Describe briefly what unconditional forgiveness means to you: _____

_____

_____

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

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