HIGHER HEIGHTS COUNSELING
INTAKE FORM (FAMILY MATTERS)

IDENTIFICATION INFORMATION: **ADULT NO. _____**

FAMILY ROLE: Husband/Father: ____ Wife/Mother: ____ Son/Brother: ____ Daughter/Sister: ___
Grandmother: ___ Grandfather: ___ Aunt: ___ Uncle: ___

Name: _____ Phone: _____

Address: _____City, St_____Zip_____

Occupation: _____ Email: _____

May we contact you and send personal information to this email? [ ] Yes [ ] No Sex: [ ] Male [ ] Female

Birth Date _____Age: _____ Marital Status: [ ] Married [ ] Single [ ] Widowed [ ] Divorced [ ] Separated [ ] Divorce Filed Education: (last year completed): _____ Currently attending school / college [ ] Yes [ ] No If yes, pursuing degree in: _____ Est. Completion_____

Role / Position in the Family Hierarchy: (i.e., Father, Mother, etc) _____

OVERALL 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:

_____

_____

Have you used drugs for other than medical purposes? [ ] Yes [ ] No

If yes, what drugs and purpose:

Drug: _____ Purpose: _____

_____ _____

Daily_____ Weekly _____ Monthly _____ Infrequent_____

Do you drink alcohol more than once a week? [ ] Yes [ ] No If yes, how frequent? _____

Daily____ Weekly____ Monthly____ Infrequent _____

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 _____

_____

Have you ever felt people were watching you? [ ] Yes [ ] No
Do people's faces ever seem distorted? [ ] Yes [ ] No
Do you ever have difficulty distinguishing faces? [ ] Yes [ ] No
Are you sometimes unable to judge distances? [ ] Yes [ ] No
Do you now or have ever heard voices? [ ] Yes [ ] No
Have you ever had hallucinations (nightmares, etc.) [ ] Yes [ ] No
Is your hearing exceptionally good? [ ] Yes [ ] No
Do you have problems sleeping? [ ] Yes [ ] No
How many hours of sleep do you get per night? _____
Do you now or ever had suicidal thoughts [ ] Yes [ ] No
If yes, when did they begin? _____ How often? _____
Have you ever attempted suicide? [ ] Yes [ ] No If yes, when _____

PERSONALITY:

Have you ever had any psychotherapy or counseling before individually or as a family? [ ] 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 Shy

Hardworking Impatient Impulsive Moody Often-Blue Calm Excitable Imaginative

Easy-Going Submissive Leader Self-Conscious Frustrated Lonely Sensitive Serious

Introvert Extrovert Hard-Boiled Likeable Quiet Withdrawn Controlling Other: _____

CURRENT EVENT INFORMATION:

What recent event prompted you to seek counseling?

_____

_____

Are you currently experiencing overwhelming sadness, grief or anxiety? [ ] Yes [ ] No

If yes, for how long? _____ Briefly explained: _____

_____

_____

Within the family unit, has there been a life changing, stress event or severe emotional upset within the last two years? [ ] Yes [ ] No If yes, explain: _____

_____

_____

What are your concerns with the family unit: _____

_____

_____

What is your contribution(s) to the current condition of your family unit?_____

_____

_____

What are your personal regrets from either past or present family interactions or exchange? _____

_____

_____

How do you approach or resolve conflict within the family unit?_____

_____

_____

What do you believe needs to change to promote healthy relationship within the family?

_____

_____

_____

PERTINENT INFORMATION:

Are you satisfied with where you are in your life? [ ] Yes [ ] No If no, briefly explain: _____

_____

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

_____

_____

How many older siblings? Brothers? _____ Sisters? _____

How many younger siblings? Brothers? _____ Sisters? _____

How would you describe your childhood experience? _____

_____

Briefly describe your childhood family dynamics, interactions or traditions:_____

_____

On a scale 1 – 10, how do you rate your childhood family _____ ('1' being the least supportive, functional or healthy)

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

_____

_____

Information about children:

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

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

_____

_____

Do you have a blended family? [ ] No [ ] Yes If yes, briefly explain: _____

_____

_____

What are the challenges, if any, with the blended family dynamics?_____

_____

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,

_____

_____

Is there anything else you would like to share that could be helpful to the process?_____

_____

_____

_____

_____

_____

_____

_____

If asked, are you willing to participant in individual therapy? [ ] Yes [ ] No If no, briefly explain_____

_____

_____

SUBMIT