Gateway Biblical Counseling
12830 Hillcrest Road, Ste D111, Dallas, Texas 75230
www.gatewaybiblicalcounseling.com

Client Intake Form

Please provide the following information for our records. Leave blank any question you would rather not answer, or would prefer to discuss with your spiritual director. Information provided here is held to the same standards of confidentiality as our counseling services.

Name: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home #:_____ Cell #:_____ Work #: _____

Email Address: _____

Please indicate below your preferred method of contact:

Email ( ) Yes ( ) No Text ( ) Yes ( ) No Phone call ( ) Yes ( ) No

Date of Birth: _____ Age: _____

Gender: _____ Marital Status: M S D W

Emergency Contact: Name: _____Phone #: _____

Relationship to Client: _____

How did you find us? _____

OCCUPATIONAL INFORMATION

Are you currently employed? ( ) Yes ( ) No

Employer Name and Address: _____

_____

_____

Length of time at present employer: _____ Position: _____

Are you satisfied with your current position? ( ) Yes ( ) No
Number of employers in last 5 years: _____

Any work-related stressors we should be aware of? _____

_____

TREATMENT HISTORY

Are you currently receiving psychiatric services, professional counseling, or psychotherapy elsewhere? ( ) Yes ( ) No

Have you had previous psychotherapy?
( ) No
( ) Yes, (Dates)_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
( ) Yes ( ) No

If yes, please list: _____

Prescribed by: _____

Have you ever been hospitalized for a psychological reason (drugs/suicide etc.)? _____

Length and reason for hospitalization: _____

_____

Where was the facility? _____

Date(s) Admitted? _____

HEALTH INFORMATION

Do you currently have a primary physician? ( ) Yes ( ) No

If yes, Name of Physician? _____

Phone Number of Physician: _____

Are you currently seeing more than one medical health specialist? ( ) Yes ( ) No

If yes, please list: _____

When was your last physical? _____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.: _____

_____

Are you currently on medication to manage a physical health concern? If yes, please list: _____

_____

Are you having any problems with your sleep habits? ( ) Yes ( ) No

If yes, check where applicable:
( ) Sleeping too little ( ) Sleeping too much ( ) Poor quality sleep
( ) Disturbing dreams ( ) other _____

How many times per week do you exercise? _____

Are you having any difficulty with appetite or eating habits? ( ) Yes ( ) No

If yes, check where applicable: ( ) Eating less ( ) Eating more ( )Bingeing ( ) Restricting

Have you experienced significant weight change in the last 2 months? ( ) Yes ( ) No

Alcohol Use: ( ) Never ( ) 1-3 times per month ( ) 1-3 times per week ( ) Other

In a typical month, how often do you have 3+ drinks in a 24-hour period? _____

How often do you engage recreational drug use? ( ) Daily ( ) Weekly ( ) Monthly
( ) Rarely ( ) Never

Do you use other tobacco products? ( ) No ( ) Yes, #packs per day_____

Have you had suicidal thoughts recently?
( ) Frequently ( ) Occasionally ( ) Rarely ( ) Never

Have you had suicidal thoughts in the past?

( ) Frequently ( ) Occasionally ( ) Rarely ( ) Never

Have you ever experienced any of the following?

Extreme depressed mood	Yes / No
Dramatic mood swings	Yes / No
Rapid speech	Yes / No
Anxiety	Yes / No
Panic attacks	Yes / No
Phobias	Yes / No
Sleep disturbances	Yes / No
Hallucinations	Yes / No
Unexplained losses of time	Yes / No
Unexplained memory lapses	Yes / No
Alcohol/substance abuse	Yes / No
Frequent body complaints	Yes / No
Eating disorder	Yes / No
Body image problems	Yes / No
Repetitive thoughts (e.g. obsessions)	Yes / No
Repetitive behaviors (e.g. frequent checking, hand washing	Yes / No
Changes in appetite	Yes / No
Extreme/uncontrolled anger	Yes / No
Sexual dysfunction	Yes / No
Changes in sexual interest	Yes / No
Homicidal thoughts	Yes / No
Suicidal attempts	Yes / No If yes, when?

FAMILY HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following?

Difficulty	**Yes / No**	**Family member**
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	Yes / No	
Panic attacks	Yes / No	
Schizophrenia	Yes / No	
Alcohol/substance abuse	Yes / No	
Eating disorders	Yes / No	
Trauma history	Yes / No	
Suicide attempts	Yes / No	
Chronic illness	Yes / No	

FAMILY OF ORIGIN

Family Member	**Age**	**Married / Divorced**	**Other Pertinent Information**
Mother			
Father			
List Siblings:			

RELIGIOUS / SPIRITUAL INFORMATION

Do you consider yourself to be ( ) Religious ( ) Spiritual ( ) Seeking ( ) Other

How would you describe the faith you practice? _____

SOCIAL INFORMATION

Are you currently in a romantic relationship? ( ) Yes ( ) No

If yes, how long have you been in this relationship? _____

On a scale of 1-10 (10 being the highest quality), how would you rate your current relationship? _____

Number and lengths of current and past marriages: _____

Past history of physical or sexual abuse? ( ) Yes ( ) No

In the last year, have you experienced any significant life changes or stressors? If yes, please explain: _____

_____

_____

Reason for seeking counseling? _____

_____

Is there anything else you would like us to know as we start the session or areas you would like to specifically address as we talk? _____

_____

_____

_____