

INDIVIDUAL INTAKE FORM

Name: _____ Date of Birth: _____
 First Middle Last

Address _____ City _____ State ___ Zip _____

Home phone number: _____ Work number: _____

Cell number: _____

Email address (for communication & mailing list): _____

Racial/Ethnic Identity (Circle one): African-American Asian White Hispanic Native American Other _____

Religious Preference _____ Local Congregation _____

Relationship Status (Circle one): Single Committed Engaged Married Separated Divorced Widowed

If married, years married _____ Spouse's Name: _____

Names/Ages of Children: _____

Miscarriages: _____ Abortions: Yes/No _____

If separated, divorced, or widowed, years/months _____ separated _____ divorced _____ widowed

If single, do you have a significant relationship? __Yes __No Significance _____ How long? _____

Names/Ages of Siblings: _____

Recent deaths of family/friends (Relation/dates) : _____

EDUCATION

High School Diploma? __Yes __No If no, highest grade completed (circle one) 1 2 3 4 5 6 7 8 9 10 11

College 1 2 3 4 Name of College _____ Degree(s) _____

Graduate School 1 2 3 4 Name of College _____ Area of Study _____

Business/Technical School _____

Did you have any learning disabilities in school? __Yes __No Specify: _____

OCCUPATIONAL INFORMATION

Employer _____ Length of Employment _____

Type of work you do _____

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MILITARY

Have you served in the US Armed Forces? Yes No Which branch of service? _____

When did you serve? _____ Where? _____

Were you deployed during wartime or in a warlike situation? Yes No Explain: _____

Have any of your family members served in the military? Explain: _____

CRIMINAL HISTORY

Have you ever been arrested? Yes No Specify the crime/offense: _____

Specify (How many times?, where?, when?): _____

Have you had a DUI? Yes No How many? _____ Date of your last DUI: _____

PHYSICAL INFORMATION

List current illness(es) or symptoms _____

List any major surgeries, serious crises, losses, or handicaps (with dates) _____

Last medical exam _____ Reason _____

Name and Address of Physician _____

Current Medications _____

FAMILY HISTORY (please include *yourself* in this and specify *whom* it is in your family):

Are your parents divorced? Yes No How old were you when they divorced? _____

Alcoholism/Drug Abuse: _____

Depression, Bipolar Depression, Schizophrenia: _____

Other Mental Illness: _____

Emotional or Verbal abuse: _____

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Physical or Sexual abuse: _____

Other significant childhood traumas: _____

COUNSELING HISTORY

Have you ever received psychotherapy, counseling, or other treatment for personal, marital, or family problems? Yes No Dates _____ Name of Professional (Dr., agency, pastor, etc.) _____

Was the counseling helpful and how? _____

Have you had thoughts of harming yourself or ending your life? _____

If yes, please describe (how long ago?; did you have a plan?): _____

Have you had thoughts of harming someone else? Him Her If yes, please explain: _____

Have you or any member of your family ever received or considered seeking help for drug or alcohol dependency? Yes. No. Date _____ Name of Professional/Agency _____

Substances Used _____

How did you hear about Christian Counselors of Mooreville? _____

Person Responsible for Payment _____

Type of Counseling: Individual Marriage Family Group

Emergency Contact Person _____ Phone #: _____

IMPORTANT QUESTIONS FOR YOU AND YOUR COUNSELOR

Please describe your reason(s) for seeking help _____

What would you like to have happen as a result of counseling? _____
