☐ Individual
☐ Couple
☐ Family

Healing Logos Christian Family Counseling, Inc.

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Initial Intake Information – Confidential Information **Date** _____

CLIENT'S NAME _____**DOB** _____

CLIENT'S NAME _____**DOB** _____

Please complete Address, City, State, Zip Code, Phone Number, and Email Address

_____

_____

Are you married_____ If so, how long have you been married? _____

Spouse/Significant Other's Name _____ DOB _____

Describe your current living situation. Do you live alone, with others, family, etc.

_____

In case of emergency call: _____ Cell Phone _____

Email: _____

If you are in a relationship, please describe the nature of the relationship (Marriage, engaged, living together but not married, serious dating) and months or years together. On a scale of 0-10 (with 0 being dissatisfied and 10 being satisfied) how satisfied would you say you are in your relationship?

_____

_____

Have you ever been divorced? (If so, how many times, and year of last divorce, what do you think caused the divorce)?

_____

What is your parent's marital status?

_____

Do you have children?

Children Name	M/F	Age	Together	Hers	His	Not at Home	Relationship with child

What is your level of education? Highest grade/degree and type of degree.

_____

What is your current occupation? How long have you been in this occupation?

_____

What is your spouse/significant other's current occupation? Length of time in this occupation.

_____

Please describe your family of origin (your relationship with your parents and siblings and their ages).

_____

_____

_____

_____

_____

_____

What brings you to counseling at this time? Is there something specific, such as a particular event? Be as detailed as you can. When did the problem begin? How long has it lasted?

Have you seen a therapist before? What was your experience with the therapist?

Specify ALL medications and supplements you are presently taking and for what reason.

If taking prescription medication, are you taking your medications daily as prescribed.
Who is your prescribing MD? Please include type of MD, name and phone number.

Who is your primary care physician? Please include type of MD, name and phone number.

Do you drink alcohol? (If so, how often; have you or anyone else considered your drinking a problem?)

Do you use recreational drugs? (if so, how often; do you or anyone else consider your use a problem?)

Do you currently have suicidal thoughts? When was the last time you had suicidal thoughts?

_____

_____

Have you ever attempted suicide? (If so, when and what method?)

_____

_____

Do you have thoughts or urges to harm others?

_____

_____

Have you ever been a victim or perpetrator of domestic violence? If so, explain.

_____

_____

Have you ever been hospitalized for a psychiatric issue? Have you ever been diagnosed for a mental health issue? If so, what was the diagnosis?

_____

Is there a history of mental illness in your family?

_____

_____

_____

Have you served in the military (If so, what branch, any combat, date of discharge)

What are your goals for counseling? Please list at least five.

_____

_____

_____

_____

_____

_____

Personal strengths: _____

Personal weakness: _____

Is it important for you to have Christian values as a part of your therapy? _____

Who would your support system consist of:

_____

_____

_____

What else would you like me to know?

_____

_____

_____

_____