INTAKE FORM

Today's Date: ____/_____/_____
centerpoint4counseling.com

Personal Information

Name:	Age:	DOB:
Work PH:	Cell PH:	Home PH:
Address:	City	State:
Zip:	# of children:	Their ages:
Circle what applies:	Single Dating Married	Separated Divorced

General Information

How did you hear about us?
_____

Briefly describe problems you want help with:
_____
_____

How much have you worked during the past two years?

Part Time Full Time Other _____

Describe your education(# of years of school, special training, etc.):
_____

Describe any psychological problems you have or have had (e.g. periods of depression, anxiety, fears, phobias, problems with anger, confusion, etc.):
_____
_____

Please list/describe any previous counseling experience(s):
_____
_____

Did anyone in your family die before you were 18 years old?

Yes No Who?_____How old were you? _____Other family deaths?
_____

Education/Employment History

Last grade completed in school: _____

Are you employed now? Yes No

Present Occupation: _____

Company Name: _____

Main occupation during past 5 years: _____

List a Few Words to Describe Your Personal Faith: _____

List Those Who Support You Most Spiritually:

Medical History

When were you last examined by a physician?

Name _____Present physician's name_____ Phone number _____

List any major health problems for which you have received treatment: _____

Do you or your family members currently have or have ever had any of the following: (Please check all that apply)

	Self	Family
HEART PROBLEMS	_____	_____
CANCER	_____	_____
NERVOUS BREAKDOWN	_____	_____
STROKE	_____	_____
CHRONIC ILLNESS	_____	_____
ALCOHOL OR DRUG ABUSE	_____	_____

LEGAL PROBLEMS _____ _____

LEARNING DISABILITY _____ _____

DEPRESSION _____ _____

OTHER _____

List everyone currently living in your residence, including family and other:

Name	Age	Relationship
Nearest Family Relative	PH:	

List any medications you are now taking (prescription and nonprescription):_____
_____

Have you been abused or assaulted?

YES NO Don't remember (Circle One)

Did you witness abuse between your parents?

YES NO DON'T REMEMBER (Circle One)

Did you witness abuse between parent and child?

YES NO DON'T REMEMBER (Circle One)

Briefly describe your childhood:_____
_____
_____

Please circle any of the following which concern you:

NERVOUSNESS	DEPRESSION	FEARS	SHYNESS
SEXUAL PROBLEMS	SUICIDAL THTS	SEPARATION	DIVORCE
FINANCES	ANGER	SELF-CONTROL	FRIENDS
SLEEP PROBLEMS	STRESS	WORK/SCHOOL	RELAXATION
HEADACHES	TIREDNESS	LEGAL MATTERS	MEMORY
AMBITION	ENERGY	INSOMNIA	DECISIONS
LONELINESS	FEEL INFERIOR	CONCENTRATE	TEMPER
CAREER CHOICES	MARITAL REL	HEALTH	EDUCATION
NIGHTMARES	CHILDREN	EATING ISSUES	
UNHAPPINESS	SEXUAL ABUSE	PHYS ABUSE	BOWELS PN
BEING A PARENT	MY THOUGHTS	STOMACH PAIN	GAMBLING
BINGE EATING	EATING TOO LITTLE	TOO HEAVY/THIN	SPIRITUALITY
UNFORGIVENESS			

Please circle any of the following strengths you have:

SYMPATHETIC	LOYAL	SENSE OF HUMOR	
GOOD LISTENER	GRACIOUS	PATIENT	
CONFIDENT	DEPENDABLE	DECISIVE	OTHER
HARD WORKER	SENSITIVE	RESPONSIBLE	ORGANIZED
LOGICAL	UNDERSTANDING	SENSE OF HUMOR	PATIENT

Please use the chart below to describe your use of drugs. Complete the "yes" or "no" lines for each drug listed, and if "yes", answer the remaining questions on the line.

	No, I Never Used	**Yes, I Used**	**If yes, age at first use**	**When using, frequency of use (daily, weekly, etc.)**	**How long since last used?**
TOBACCO					
ALCOHOL					
MARIJUANA					

	No, I Never Used	Yes, I Used	If yes, age at first use	When using, frequency of use (daily, weekly, etc.)	How long since last used?
COCAINE	.				
METH/ AMPHETAMINES					
HALLUCINOGENS					
COFFEE	.				
OTHER					

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Please add any additional information which you feel may be helpful to us:

_____

_____

_____