CLIENT INTAKE FORM

Becomer Counseling Services
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Please take your time in providing information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information is **CONFIDENTIAL**.

Name ____ Date ____________________

Street Address____

City, State, Zip ____

Mobile Phone _______________________ Home _____________Wk_________________

Primary Email: ____

Secondary email:____

Age _______ Date of Birth ________________________Gender: M_____ F ________

Marital Status (please circle) Married (Years ______) Separated Divorced

Widowed Single Single in a Relationship Single & Engaged

Previous Marriage(s): First (Years _____) Second (Years _____)

Third (Years_____) Fourth (Years____)

Spouse's Name ____

Children with Current Spouse (names & ages)

_____________________________(____): _____________________________ (______)

_____________________________(____); _____________________________ (______)

_____________________________(____); _____________________________ (______)

Children with Previous Marriage(s) [names & ages] __________________ (______)

_____________________________(____); _____________________________ (______)

______________________________(__); _____________________________ (______)

______________________________(__); _____________________________ (______)

Occupation ___________________________ Employer _________________________

Contact in Case of Emergency:

Name _____________________________________

Phone: ___________________ Address _________________________________

Referred by:

_____ Pastor/Church ____
_____ Family/friend ____
_____ My Website: http://www.BecomerCounseling.com
_____Other ____

Which of the following Counseling Services are you currently requesting?

____ Individual Counseling ____ Premarital Counseling
____ Marriage Counseling ____ Family/Blended Family Counseling
____ Other ____

NOTE: Please observe my cancellation policy, which is: Please honor all appointments as scheduled, and observe a minimum of 24 hours advanced notice for any cancellation, or you may pay the regular session fee.

First Session Questions

I. PHYSICAL HEALTH

Name of primary physician? ____

How is your health generally? ____

____

Have you had any serious health problems: _______ Explain: _________________

____

____

____

____

____

Are you presently taking medication? If so, what?

Please list any medications, herb, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If our have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement	Dosage	Condition	Date Began/Stopped

Are you having difficulty with sleep? If so, please describe:
____

____

Are there any specific health problems you ae currently experiencing? If so, please describe____

____

How would you rate your current sleeping habits?

___ Poor ___ Unsatisfactory __ Satisfactory ___ Good _____Very Good

If you are having problems, in which phase of sleep are you experiencing issues?

__ Falling asleep __ Staying asleep __ Awakening early __ Sleep apnea

Please list any other specific sleep problems you are currently experiencing:

____

____

Have you experienced changes in your appetite or your eating habits? If so, please describe:

____

____

How many times a week do you generally exercise? __________ What types of exercise do you participate in?

____

Are you currently experiencing any chronic pain? __No ____ Yes If so, please describe.

____

Are you currently experiencing overwhelming sadness, grief or depression? _____Yes _____ No

Are you currently experiencing anxiety, panic attacks or have any phobias? _____Yes _____ No If YES, when did you begin experiencing this?

____

____

Please describe any major losses or traumas you have experienced (childhood and adulthood):

____

____

____

____

What significant life changes or stressful events have you experienced recently?

____

____.

Please describe **current** use of alcohol, cigarettes/tobacco, and/or recreational drugs.

____

____

____

Please describe **previous** use of alcohol, cigarettes/tobacco, and/or recreational drugs:

____

____

____

II. FAMILY OF ORIGIN HISTORY:

Where were you born?

____

Where did you grow up?

____

____ City ____ Suburbs ____ Country/Rural

Are your parents living?____

Are (were) they divorced, separated? ________________________________

Please describe your father:

____

____

____

____

____

Please describe your mother:

____

____

____

____

Briefly describe the nature of your family when you were a child:

____

____

____

Describe your relationship with your parents (step-parents, if applicable), both currently and in the past.

Past **Present**

Mother____

____

Father____

Step mother ____

Step father ____

Who did you live with growing up? ____

Mother's occupation: ____

Father's occupation: ____

Do you consider your family to have been an emotionally and mentally healthy family? __________

Please explain: ____

____

____

____

Please list your parents and siblings. Please use additional space on back if needed.

Name	Age	Relationship	Where do they live now?	If deceased, age and cause of death

Where did you come in this birth order? ____

Briefly describe the relationship you have with your siblings now:

____

____

____

Describe the relationship you had with your siblings when you were a child:

____

____

____

Who do you feel closest to in your family? ____________________________________

What makes you feel closest to this person? __________________________________

____

____

____

____

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Condition	Please Circle	List Family Member
Alcohol/Substance Abuse	Yes | No	
Anxiety	Yes | No	
Depression	Yes | No	
Domestic Abuse	Yes | No	
Sexual Abuse	Yes | No	
Eating Disorder	Yes | No	
Obesity	Yes | No	
Obsessive Compulsive Disorder	Yes | No	
Schizophrenia	Yes | No	
Suicide Attempts	Yes | No	
Other diagnosed mental health condition?	Yes | No	

III. SPIRITUAL LIFE

In what faith or religion were you raised?

___

Are you practicing your faith now? ___

What place does God/church/spirituality have in your life?

___

___

___

Church affiliation

___

Would you like prayer as part of your counseling? ___

Do you come from a religious family? Please explain briefly:

___

___

___

IV. SOME QUESTIONS ABOUT YOU

Tell me about your work:

___

___

Where do you work?

___

How long have you worked there? ___

Do you like your work? Please explain:

___

___

Have you ever been in counseling before? ___

When? ___

Who are the people in your life who mean the most to you?

____

____

What is important to you?

____

____

If you have a problem, who are you most likely to share it with?

____

With whom do you enjoy spending time?

____

What are your interests?

____

____

What do you enjoy doing in your free time? What do you do to relax?

____

____

What are your plans for the future?

____

____

What accomplishment are you most proud of?

____

____

What are three words you would use to describe yourself?

____

Do you use alcohol or drugs? If so, please describe

Have you ever experienced sexual difficulties? If so, please explain:

What else would you like your therapist to know about you, OR about what brings you to counseling today?

What do you hope to achieve through the counseling process?

Name ____ **Date** ________________

Use checkmarks to indicate which of the following areas are **currently** problems for you, and are reasons for your coming in for counseling.

- ☐ Feeling inferior to others
- ☐ Under too much pressure and feeling stressed
- ☐ Feeling down or unhappy
- ☐ Feeling nervous or anxious
- ☐ Feeling lonely
- ☐ Experiencing guilt feelings
- ☐ Suspicious feelings toward other people
- ☐ Afraid of being on your own
- ☐ Angry feelings
- ☐ Feeling homesick
- ☐ Feeling down on yourself
- ☐ Feeling you don’t belong here
- ☐ Concerns about finances
- ☐ Feeling cut off from your emotions
- ☐ Difficulty expression emotions
- ☐ Concerns about physical health
- ☐ Concerns about emotional stability
- ☐ Lacking self-confidence
- ☐ Feeling fat even though your weight is below average
- ☐ Eating and then vomiting to control weight
- ☐ Use of alcohol
- ☐ Use of non-prescription drugs
- ☐ Getting into trouble
- ☐ Difficulty concentrating while doing school work
- ☐ Getting grades that are lower than you want
- ☐ Lacking assertiveness in some situations
- ☐ Having difficulty being open with other people
- ☐ Difficulty communicating with boyfriend/girlfriend
- ☐ Communication difficulties with spouse
- ☐ Difficulties making friends
- ☐ Difficulties keeping friends
- ☐ Difficulties communicating with parents
- ☐ Feeling pressured by parents’ expectations
- ☐ Feeling controlled (manipulated) by parents
- ☐ Thought of taking your own life
- ☐ Wondering “Who am I?”
- ☐ Feeling confused about right and wrong
- ☐ Difficulty living up to religious beliefs
- ☐ Difficulty making decisions
- ☐ Confused about how far to go sexually
- ☐ Feeling guilty about sexual activities
- ☐ Confused about what to do with sexual feelings
- ☐ Difficulties in sexual relations with boyfriend/girlfriend
- ☐ Disagreements with spouse concerning sex
- ☐ Feeling sexually attracted to members of your own sex
- ☐ Feelings related to having been sexually molested
- ☐ Other (specify)