

Selah Biblical Counseling CLIENT INTAKE FORM

Primary Client Name:

Street Address:

City:

State:

Zip:

Home Phone

Work

Mobile

May we call you at your... home? work? mobile?

May we leave a voicemail? yes no

Email:

Birthdate: Age: Gender: male female

Occupation:

Education Level:

Spouse's Education Level:

Marital Status:

Name of Spouse:

Marriage Date:

Please list any other immediate family members:

Name	Age	Relationship to you

If you have been married before, please list those marriages:

Previous Spouse's Name	Marriage Date	Divorce Date	Death Date

PERSONAL CONCERNS

Why are you coming to counseling and what do you hope to gain from it?

How much are you troubled by this? Constantly Often Somewhat Not much

Comments concerning this problem:

Have you been in counseling before? yes no

If so, for each incidence complete the following:

Counselor's Name	Problem	Duration	Results

THOUGHTS AND BEHAVIORS

How often do the following thoughts occur to you?

Life is hopeless.	Never	Rarely	Sometimes	Frequently
I am lonely.	Never	Rarely	Sometimes	Frequently
No one cares about me.	Never	Rarely	Sometimes	Frequently
I am a failure.	Never	Rarely	Sometimes	Frequently
Most People don't like me.	Never	Rarely	Sometimes	Frequently
I want to die.	Never	Rarely	Sometimes	Frequently
I want to hurt someone.	Never	Rarely	Sometimes	Frequently
I am so stupid.	Never	Rarely	Sometimes	Frequently
I am going crazy.	Never	Rarely	Sometimes	Frequently
I can't concentrate.	Never	Rarely	Sometimes	Frequently
I am so depressed.	Never	Rarely	Sometimes	Frequently
God is disappointed in me.	Never	Rarely	Sometimes	Frequently
I can't be forgiven.	Never	Rarely	Sometimes	Frequently
Why am I so different?	Never	Rarely	Sometimes	Frequently
I can't do anything right.	Never	Rarely	Sometimes	Frequently
People can hear my thoughts.	Never	Rarely	Sometimes	Frequently
I have no emotions.	Never	Rarely	Sometimes	Frequently
Someone is watching me.	Never	Rarely	Sometimes	Frequently
I hear voices in my head.	Never	Rarely	Sometimes	Frequently
I am out of control.	Never	Rarely	Sometimes	Frequently

Rate the following symptoms:

Excessive anger, easily frustrated	Never	Sometimes	Frequently
Mood swings (depression – manic)	Never	Sometimes	Frequently
Excessive guilt or shame	Never	Sometimes	Frequently
Loss of energy	Never	Sometimes	Frequently
Loss of interest in activities	Never	Sometimes	Frequently
Suicidal thoughts	Never	Sometimes	Frequently
Suicide attempts How many?	Never	Sometimes	Frequently
Lying	Never	Sometimes	Frequently
Manipulation	Never	Sometimes	Frequently
Hyperactivity	Never	Sometimes	Frequently
Change or loss of friends	Never	Sometimes	Frequently
Sexual problems	Never	Sometimes	Frequently
Self-mutilation (e.g., cutting)	Never	Sometimes	Frequently
Excessive stress	Never	Sometimes	Frequently
Anxiety or excessive fears	Never	Sometimes	Frequently
Learning disabilities	Never	Sometimes	Frequently
Work or school related problems	Never	Sometimes	Frequently
Hallucinations, delusions, thought distortions	Never	Sometimes	Frequently
Obsessive thoughts and/or compulsive behaviors	Never	Sometimes	Frequently
Poor impulse control	Never	Sometimes	Frequently

Please comment (with examples, frequency, duration, effects on you) about each of the thoughts and behaviors that occur frequently or are a concern to you:

Enter information here if there wasn't room elsewhere:

EMERGENCY CONTACT

Who should we contact in case of an emergency?

Name:

Address:

Home Phone:

Mobile Phone:

For office use:

Therapist:

Diagnostic code:

Date of first session:

fee:

Insurance Carrier:

Y N