Selah Biblical Counseling CLIENT INTAKE FORM

Primary Client Name:					
Street Address:					
City:	State:			Zip:	
Home Phone	Wo	ork		Mobile	
May we call you at your	home?	work?	mobile?		
May we leave a voicemail?	yes	no			
Email:					
Birthdate:	Age:	Gender:	mal	le female	
Occupation:					
Education Level:					
Spouse's Education Level:					
Marital Status:					
Name of Spouse:					
Marriage Date:					
Please list any other imme	ediate famil	y members:			
Nam	e		Age	Relat	ionship to you
		<u> </u>			
If you have been married	before, plea	se list those	marria	ges:	
Previous Spouse's I	Name	Marriag	e Date	Divorce Date	Death Date

If your spouse has been married before, please list those marriages:

Previous Spouse's Name	Marriage Date	Divorce Date	Death Date

PERSONAL INFORMATION
Are you attending a church? yes no
Name and denomination?
Do you have a personal relationship with Jesus? yes no Unsure
Are spiritual issues important to you? yes no
Do you have spiritual resources that could help you overcome your problems? yes no
If yes, what are they?
Would you like prayer as part of your counseling? yes no
Who referred you to our center?
May we contact them? yes no
How would you rate your health?
How many hours do you sleep each night?
How would you rate your diet?
Has your appetite or weight changed lately? yes no
Do you have addictive/abusive issues with: Alcohol Illegal Drugs Prescriptions Sex
Porn Gambling Gaming Other:
If you are currently on medication, complete the following:

Medication	Dosage	Purpose	Prescribing Physician

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 th	e following:				
Counselor's Name	Problem	Durat	ion	Results	

THOUGHTS AND BEHAVIORS

How often do the following thoughts occur to you?

and the same and t				
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

ease comment (with examples, frequency, duration, effects on you) about	each of the thoughts and
haviors that occ	ur frequently or are a concern to you:	
tor information	here if there wasn't room elsewhere:	
iter information	nere ii there wash t room eisewhere:	

EMERGENCY CONTACT

Who should we contact in case of an emergency?

name:		
Address:		
Home Phone:	ı	Mobile Phone:
For office use:		
For office use: Therapist:		
Diagnostic code:		
Date of first session:	fee:	
Insurance Carrier	٧	N