

FAITH COUNSELING CENTER
7585 E. Redfield Rd. Suite 211 Scottsdale AZ 85260 480.951.5343

CLIENT INTAKE INFORMATION FORM

The information requested in this form will be kept confidential, and will help your counselor to assist you. Please fill out the form as completely as you can. Use a "x" to indicate your choices. Write in words or numbers where asked.

GENERAL INFORMATION

Last Name _____ First Name _____ Middle Initial ____
Birth Date ____ / ____ / ____ . Social Security # ____ - ____ - ____ . Male Female
Street Address _____ Apt # _____
City _____ State _____ Zip _____
Home Telephone () _____ Work Telephone () _____ Other # _____
Guardian/parent (if under 18) _____
Referred by: _____ May we thank your referring source? _____
Reason for Referral _____
Reason for choosing this Center _____
Religious/denominational preference _____
Your congregation/church/temple _____
Your racial/ethnic identity: African-American Native-American Asian-American
 White/Caucasian Hispanic Other

EMPLOYMENT/EDUCATION INFORMATION

Full time employee _____ Full time at home _____ Part-time employee _____ Unemployed _____
Place of employment _____ Length of Employment _____ Years
Type of work you do _____
Highest Level of Education Completed: High School College degree Graduate degree
 Professional training Other _____

FAMILY INFORMATION

Relationships: Single Engaged Married Separated Divorced Widow(er) Cohabiting
Parents. *Mother*: living, age _____ Deceased. *Father*: living, age _____ Deceased
Siblings. Number of *Brothers* []. Number of *Sisters* []. Only Child.
List ages of *Brothers* [] of *Sisters* [].
Names and ages of your *Children*: _____
_____ Have any of your children died? _____

PAYMENT METHOD Self Other

Party responsible for payment; if other than client: Name: _____

Address: _____ Telephone: _____

Do you plan to file for insurance for these services? Yes No

Are you covered by an Employee Assistance Program? Yes No

May we send mailings to your home? (i.e., Newsletter) Yes No

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PROBLEM DEFINITION

What is your reason for seeking help now? _____

Are any of the following conditions a problem to you at this time? (Check the ones that apply)

<input type="checkbox"/> Anxiety
<input type="checkbox"/> Grief
<input type="checkbox"/> Depression
<input type="checkbox"/> Irrational fears
<input type="checkbox"/> Nervousness
<input type="checkbox"/> Loneliness
<input type="checkbox"/> Anger
<input type="checkbox"/> Marriage problems
<input type="checkbox"/> Sexual problems
<input type="checkbox"/> Loss of work/job

<input type="checkbox"/> Self esteem
<input type="checkbox"/> Stress
<input type="checkbox"/> Substance abuse
<input type="checkbox"/> Chronic fear
<input type="checkbox"/> Guilt feelings
<input type="checkbox"/> Suicidal feelings
<input type="checkbox"/> Loss of hope
<input type="checkbox"/> Rage
<input type="checkbox"/> Relationship to parents
<input type="checkbox"/> Relationship to children

<input type="checkbox"/> Loss of meaning in life
<input type="checkbox"/> Loss of faith in God
<input type="checkbox"/> Conflicts at work
<input type="checkbox"/> Religious doubts
<input type="checkbox"/> Other (list)

What would you like to see happen as a result of psychotherapy or counseling?

MEDICAL/PSYCHOLOGICAL HISTORY

Name and address of your physician: _____

When was your last medical examination? _____

Are you suffering any physical illnesses or symptoms at this time? _____

List major surgeries or illnesses in the last five years: _____

List current medications: _____

Have you or any member of your family received help for drug or alcohol dependency? Yes No

When? _____ Name of helping agency _____

Have you received psychotherapy or counseling in the past? Yes No. When? _____

Name of treating therapist: _____

Make a check mark if any of these statements are true:

- Do you have thoughts of harming yourself or others?
- Are thoughts of harming yourself or others a frequent occurrence?
- Do you dwell on these thoughts and wonder if you can control them?
- Have you sought professional help because of these thoughts or feelings?

ACKNOWLEDGEMENT Please sign and date this document attesting that the information you have written on this form is accurate to the best of your knowledge.

CLIENT'S SIGNATURE _____

DATE _____