FAITH
BIBLE CHURCH

I

INTAKE INFORMATION FORM

We are honored that you have chosen Faith Bible Church to provide counseling services. We hope to do our best to assist you in making your counseling experience meaningful.

Please fill out the pages below and let us know if you have any questions.

ADULT INTAKE INFORMATION FORM

Client Name: _____ Date: _____

Gender: ◯ Female ◉ Male Date of Birth: _____ Age: _____

Form completed by (if someone other than client) _____

Primary reason(s) for seeking services (Please check the following that applies):

- ☐ Marital Problems
- ☐ Parenting
- ☐ Relationship
- ☐ Family
- ☐ Anger Management
- ☐ Anxiety
- ☐ Coping
- ☐ Depression
- ☐ Eating Disorder
- ☐ Fear/Phobias
- ☐ Mental Confusion
- ☐ Sexual Concerns
- ☐ Sleeping Problems
- ☐ Addictive Behaviors
- ☐ Alcohol/Drugs
- ☐ Eating Habits
- ☐ Job
- ☐ Medical/Health Problems
- ☐ Other Mental Health

Concerns (Specify)

Marital Status: (More than one answer may apply)

- ☐ Single
- ☐ Legally Married Length of time:
- ☐ Widowed Length of time:
- ☐ Divorce in Process Length of time:
- ☐ Separated Time: Length of time:
- ☐ Annulment Time: Length of time:
- ☐ Unmarried, Living Together Length of Time:
- ☐ Divorced Length of Time:

Total Number of Marriages:

Legal:

Are you involved in any criminal proceedings or litigation at the present time? ◯ Yes ◉ No
If yes, describe:

Are you presently on probation or parole? ◯ Yes ◯ No
If yes, describe:

Education:
Level of education completed:

- ☐ GED
- ☐ High School
- ☐ Some College
- ☐ Associate
- ☐ Bachelor's
- ☐ Master's
- ☐ Doctorate
- Other

Currently enrolled in school? ◯ Yes ◯ No

If yes, where: _____

Special circumstances (e.g., learning disabilities, gifted): _____

Military:

Military experience? ◯ Yes ◯ No Combat experience? ◯ Yes ◯ No

Where: _____

Branch: _____ Discharge Date: _____

Type of discharge: _____

Family Information:

RELATIONSHIP	NAME	AGE	LIVING		LIVING WITH YOU	
Mother			Yes ◯	No ◯	Yes ◯	No ◯
Father			Yes ◯	No ◯	Yes ◯	No ◯
Spouse			Yes ◯	No ◯	Yes ◯	No ◯
Children (1)			Yes ◯	No ◯	Yes ◯	No ◯
Children (2)			Yes ◯	No ◯	Yes ◯	No ◯
Children (3)			Yes ◯	No ◯	Yes ◯	No ◯

Significant Others (e.g., brothers, sisters, grandparents, step-relatives/half-relatives). Please specify.

		Yes ◯	No ◯	Yes ◯	No ◯
		Yes ◯	No ◯	Yes ◯	No ◯
		Yes ◯	No ◯	Yes ◯	No ◯
		Yes ◯	No ◯	Yes ◯	No ◯

Medical/Physical Health: (Please check the following that applies):

- ☐ AIDS
- ☐ Alcoholism
- ☐ Abortion
- ☐ Anemia
- ☐ Bladder Control
- ☐ Cancer
- ☐ Chronic Pain
- ☐ Dizziness
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ Epilepsy
- ☐ Eating Problems
- ☐ Fatigue
- ☐ Hepatitis
- ☐ Headaches/Migraines
- ☐ High Blood Pressure
- ☐ Mononucleosis
- ☐ Miscarriages
- ☐ Nausea
- ☐ Neurological Disorders
- ☐ Sexual Problems
- ☐ Sleeping Disorders
- ☐ Stomach Aches
- ☐ Sexually Transmitted Diseases
- ☐ Thyroid Problems
- ☐ Vomiting

Other (describe):

List any current health concerns:

List any recent health or physical changes:

Current Prescribed Medications	Dose	Length of Time	Purpose	Side Effects

Current Over-the-Counter Medications	Dose	Length of Time	Purpose	Side Effects

Family history of medical problems:

Please check if there have been any recent changes in the following:

- ☐ Sleep Patterns
- ☐ Eating Patterns
- ☐ Behavior
- ☐ Energy Level
- ☐ Physical Activity Level
- ☐ General Disposition
- ☐ Weight
- ☐ Nervousness/ Tension

Describe changes in areas in which you checked above:

Please tell us about your prior counseling and/or treatment history:

Family Information:	Yes	No	When	Where
Counseling/Psychiatric Treatment	◯	◯		
Reason / Diagnosis				
Suicidal Thoughts/ Attempts	◯	◯		
Reason / Diagnosis				
Drug/Alcohol Treatment	◯	◯		
Reason / Diagnosis				
Hospitalizations	◯	◯		
Reason / Diagnosis				
Involvement with Self-help Groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	◯	◯		
Reason / Diagnosis				

Have any of your family members or significant others had counseling or treatment in any of the above areas?

Do you drink alcohol? ◯ Yes ◯ No
If yes, how often and in what quantity?

Have you used/abused drugs, alcohol or controlled substances? ◯ Yes ◯ No
If yes, please explain:

Does/Has someone in your family have/had a problem with drugs or alcohol? ◯ Yes ◯ No
If yes, please describe:

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ◯ Yes ◯ No
If yes, describe:

Have drugs or alcohol created a problem for your job/relationship? ◯ Yes ◯ No
If yes, describe:

Behavioral History:

Please check behaviors and symptoms that are problematic for you:

- ☐ Aggression
- ☐ Alcohol Dependence
- ☐ Anger
- ☐ Anemia
- ☐ Hallucinations
- ☐ Anxiety
- ☐ Avoiding People
- ☐ Chest Pain
- ☐ Cyber Addiction
- ☐ Depression
- ☐ Disorientation
- ☐ Distractibility
- ☐ Dizziness
- ☐ Drug Dependence
- ☐ Eating Disorder
- ☐ Phobias/Fears
- ☐ Fatigue
- ☐ Gambling
- ☐ Sexual Addiction
- ☐ Heart Palpitations
- ☐ High Blood Pressure
- ☐ Hopelessness
- ☐ Impulsivity
- ☐ Irritability
- ☐ Judgment Errors
- ☐ Loneliness
- ☐ Memory Impairment
- ☐ Mood Shifts
- ☐ Hyperactivity
- ☐ Panic Attacks
- ☐ Pornography
- ☐ Disruptive Thoughts
- ☐ Spending Problems
- ☐ Sexual Difficulties
- ☐ Sleeping Problems
- ☐ Speech Problems
- ☐ Suicidal Thoughts
- ☐ Disorganized Thoughts
- ☐ Trembling
- ☐ Withdrawing
- ☐ Worrying
- ☐ Social Problems

Other (Specify):

Briefly discuss how the above symptoms impact your ability to function:

Does anyone in your family have a history of anxiety, depression, or other mental health problems? ◯ Yes ◯ No

If yes, describe:

Stress Indicators:

Were there special, unusual, or traumatic circumstances that affected you in childhood? (i.e. – car accidents, domestic violence, violent trauma, abuse, natural disasters, significant loss) ◯ Yes ◯ No

If yes, please describe:

Please check any events that have occurred in the last 12 months:

- ☐ Moving
- ☐ Marriage
- ☐ Natural Disaster
- ☐ Divorce
- ☐ Car Trouble
- ☐ Job Change
- ☐ Financial Problems
- ☐ Birth of a Child
- ☐ Death of a Close Family Member/Friend

COUNSELING GOALS

What would you like to see accomplished in your counseling?

1.

2.

3.

4.

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