Grace Redeemer Church Counseling Intake Form

Personal Information

Date: ______________________________

First Name: ______________________________ Last Name: ______________________________

Email: ____

Address: ____

City: ______________________________ State: ________ Zip: ______________

Phone #: ______________________________ Date of Birth: ____________________ Sex: Female Male

Marital Status: Single Significant Relationship Engaged Married Divorced Living Together

Highest Level of Education: Grade School High School Some College College Grad Graduate Degree

Occupation: ____

Presenting Problems and Concerns

Describe the problem that brought you here today:

____

____

How long has it been an issue? ____________________

What steps have you taken to address this issue? ______________________________

____

Please check all of the behaviors and symptoms that you consider problematic as it relates to yourself *(select all that apply)*:

Difficulty concentrating	Change in appetite	Paranoia
Hyperactivity	Lack of motivation	Racing thoughts
Impulsivity	Isolation	Too much energy
Boredom	Anxiety/Worry	Mood swings
Poor memory	Panic attacks	Social discomfort
Phobias	Obsessive thoughts	Sleep problems
Compulsive behaviors	Sadness/Depression	Loss of pleasure
Hopelessness	Helplessness	Thoughts of death
Self-harm behaviors	Loneliness	Low self-esteem
Guilt/Shame	Fatigue	Nightmares
Eating problems	Flashbacks	Alcohol/Drug use
Relationship problems	Work/School problems	Hearing voices
Visual hallucinations	Anger	Hypersensitivity

Other: ____

Are your problems affecting any of the following?

Work/School	Self-esteem	Relationships
Hygiene/Ability to care for self	Housing	Legal matters
Finances	Recreational Activities	Sexual activity
Health	Everyday tasks/Functioning	Ability to care for others (dependents)

Have you ever had thoughts, made statements, or attempted to hurt yourself? Yes No If yes, pls describe:

Have you ever had thoughts, made statements, or attempted to hurt someone else or property? Yes No
If yes, please describe:

Do you have access to weapons? Yes No If yes, please explain:

Do you have: Current Past Pending Legal Charges (retraining order, etc)? Yes No If yes, pls explain:

How would you describe your religious background and your current beliefs about God?

How would you describe your partner or spouse's religious background and current beliefs? (if applicable)

Past/Present Counseling/Therapy

Describe:

Begin Date: End Date: Estimated number of sessions:
Initial reason for counseling:

How helpful was the counseling/therapy?
Reason for ending?
List common worries or anxieties in your life, include descriptions and intensities:

Family Background **(if never married, skip this section)**

Name of Spouse:
Spouse's Occupation:
Living with you now? Yes No Is your spouse willing to come to counseling? Yes No

Date of Marriage: ____________________ Your age when marriage took place: ______________________

Spouse's age when marriage took place: ________ How long did you know your spouse before marriage? ______

Have you ever filed for divorce? Yes No Are there any previous marriages? Yes No

Give brief information about any previous marriage(s):

____

____

List name(s), gender(s) & age(s) of your children:

____

____

Any foster/adoptive children? Yes No

Any difficulties conceiving children, including any miscarriages or abortions? Yes No

Family History

Is your mother still living? Yes No Mother's age (if living)? ______________________________

Mother's health? Good Fair Bad Quality of relationship with your mother:

____

____

Is your father still living? Yes No Father's age (if living)? ______________________________

Father's health? Good Fair Bad Quality of relationship with your father:

____

____

Rate your parents' marriage: Unhappy Average Happy Very Happy

Rate your childhood life: Unhappy Average Happy Very Happy

Have you had any abusive or extremely difficult experiences in your life or family? Yes No

How many brothers and sisters do you have? _______________

Where are you in the birth order of your siblings? _______________

Medical Background

Rate your physical health: Very Good Good Average Declining Other

List current medicine(s) prescibed to you:

Medication	Dosage	Date 1st Prescribed	Prescribed by	Reason

Allergies and/or adverse reactions to medication? Yes No If yes, please list:

Please list past and present medical conditions (e.g., allergies, seizures, chronic disease, sleep issues, etc.):

Describe any surgeries, other hospitalizations, injuries or limitations:

Substance Use History

Substance Type	Current Use (last 6 months)				Past Use				
	Yes	No	Frequency	Amount	Yes	No	Age at initial use	Frequency	Years Used
Tobacco									
Caffeine									
Alcohol									
Marijuana									
Cocaine/Crack									
Ecstasy									
Heroin									
Inhalants									
Methamphetamines									
Pain Killers									
LSD									
PCP									
Steroids									
Benzodiazepines									
Other:									

Have you had withdrawal symptoms when trying to stop using any substances? Yes No If yes, pls describe:

Have you ever had problems with work, relationships, health, legal consequences, etc., due to substance use? Yes No

If yes, please describe: ______________________________

Is there anything else you would like to tell us on this questionnaire?