For counselor use only

Intake Date:	
Group/Counselor:	
Fee:	Previous client: yes or no
Dates of previous counseling:	

ADULT INFORMATION FORM

Welcome to the Spirit Christian Counseling Center. In order to serve you better, we request that you take a few moments to fill out the following information.

How did you find out about us? (Please circle and be specific)

FRIEND DR. REFERRAL INTERNET PSYCHOLOGY TODAY

OTHER _____

Client Full Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

Date of Birth _____ Age _____ Male _____ Female _____

Occupation_____ Employed by _____

May we call you at your home? ___Yes ___No May we call you at your office? __Yes ___No

May we write you at your home? __Yes __No

May we leave a message at your home? _____ May we leave messages at your Office? _____

May we send appointment reminders or receipts via email? _____

EMERGENCY CONTACT INFORMATION:

Name: _____

Address: _____

Relationship to Client: _____

Telephone Number: _____Alternate Phone Number:_____

Family Physician/Psychiatrist Name: _____

Telephone Number: _____

EMERGENCY INFORMATION

Medical Conditions: _____

_____

Medications: _____

_____

CURRENT MARITAL STATUS:

_____ Never Married ____ Married ___Divorced ___Separated ___ Widowed

Name of Spouse (if applicable) _____

Date of Marriage _____

Spouse Occupation _____ Employed by _____

Your Education Level: _____ GED _____ High School Diploma

_____ College Degree _____ Graduate Degree Degree In _____

Spouse's Education Level: _____ GED _____ High School Diploma

_____ College Degree _____ Graduate Degree Degree In _____

PREVIOUS MARITAL HISTORY:

Self:

Name of Previous Spouse	Date of Marriage	Date of Divorce/Death
_____	_____	_____
_____	_____	_____
_____	_____	_____

Spouse:

Name of Previous Spouse	Date of Marriage	Date of Divorce/Death
_____	_____	_____
_____	_____	_____
_____	_____	_____

Children:

Name	Gender	Age	Father's/Mother's First Name
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PERSONAL INFORMATION:

Are you currently attending a church? ____ Yes ____No

If yes, what is the name of the church? _____

What is the denomination of the church? _____

Are you a born-again Christian? ___ Yes ___No ___Unsure

Are religious or spiritual issues important in your life? ____Yes ____No

Are you aware of any religious or spiritual resources in your life that could be used to help you overcome your problems? ____ Yes ____ No

If yes, what are they? _____

How would you rate your health? _____

How many hours do you sleep each night? _____

Do you experience food cravings? _____ Yes _____ No

If so, for what items? _____

How would you rate your diet?

___ Very Healthy ___Healthy ___Average ___Needs Improvement ___Poor

Are you currently on medication? _____ Yes _____ No

If so, please complete the following:

Medication	Dosage	Physician	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PERSONAL CONCERNS:

What are you seeking help for? _____

_____

How much are you troubled by this?

_____ Constantly _____ Often _____Somewhat _____ Not Very Much

Comments concerning this problem: _____

_____

_____

Have you been in counseling before? _____Yes _____ No

If so, for each incidence you remember, please complete the following (use back of this page if needed.)

1. Who was the counselor? _____
   What was the problem? _____
   How many sessions over what period of time? _____
   What were the results? _____
2. Who was the counselor? _____
   What was the problem? _____
   How many sessions over what period of time? _____
   What were the results? _____

3. Who was the counselor? _____

What was the problem? _____

How many sessions over what period of time? _____

What were the results? _____

THOUGHTS AND BEHAVIORS

Please check how often the following thoughts occur to you:

1. Life is hopeless.	___ Never	___ Rarely	___ Sometimes	___ Frequently
2. I am lonely.	___ Never	___ Rarely	___ Sometimes	___ Frequently
3. No one cares about me.	___ Never	___ Rarely	___ Sometimes	___ Frequently
4. I am a failure.	___ Never	___ Rarely	___ Sometimes	___ Frequently
5. Most people don't like me.	___ Never	___ Rarely	___ Sometimes	___ Frequently
6. I want to die.	___ Never	___ Rarely	___ Sometimes	___ Frequently
7. I want to hurt someone.	___ Never	___ Rarely	___ Sometimes	___ Frequently
8. I am so stupid.	___ Never	___ Rarely	___ Sometimes	___ Frequently
9. I am going crazy.	___ Never	___Rarely	___ Sometimes	___ Frequently
10. I can't concentrate.	___ Never	___Rarely	___ Sometimes	___ Frequently
11. I am so depressed.	___ Never	___Rarely	___ Sometimes	___ Frequently
12. God is disappointed in me.	___ Never	___Rarely	___ Sometimes	___ Frequently
13. I can't be forgiven.	___ Never	___ Rarely	___ Sometimes	___ Frequently
14. Why am I so different?	___ Never	___ Rarely	___ Sometimes	___ Frequently
15. I can't do anything right.	___ Never	___ Rarely	___ Sometimes	___ Frequently
16. People hear my thoughts.	___ Never	___ Rarely	___ Sometimes	___ Frequently
17. I have no emotions.	___ Never	___ Rarely	___ Sometimes	___ Frequently
18. Someone is watching me.	___ Never	___ Rarely	___ Sometimes	___ Frequently
19. I hear voices in my head.	___ Never	___ Rarely	___ Sometimes	___ Frequently
20. I am out of control.	___ Never	___ Rarely	___ Sometimes	___ Frequently

Please comment (e.g., examples, frequency, duration, effects on you) about each of the above thoughts that occur frequently or are a concern to you. Use the back of this sheet if necessary.

_____

_____

_____

_____

_____

_____

SYMPTOMS

Please check the behavior and symptoms that occur to you more often than you would like them to take place.

___ Aggression
___ Alcohol Dependence
___ Anger
___ Antisocial Behavior
___ Anxiety
___ Avoiding People
___ Chest Pain
___ Depression
___ Disorientation
___ Distractibility
___ Dizziness
___ Drug Dependence
___ Eating Disorder
___Elevated Mood
___ Fatigue
___ Hallucinations
___ Heart Palpitations
___ High Blood Pressure
___ Hopelessness
___ Impulsivity
___ Irritability
___ Judgment Errors
___Loneliness
___ Memory Impairment
___ Mood Shifts
___ Panic Attacks
___ Phobias/Fears
___ Recurring Thoughts
___Sexual Difficulties
___ Sick Often
___ Sleeping Problems
___ Speech Problems
___ Suicidal Thoughts
___ Thoughts Disorganized
___ Trembling
___ Withdrawing
___ Worrying
___ Other (Specify)
_____
_____
_____
_____

Please give examples of how each of the symptoms that you checked impairs your ability to function (i.e., socially, emotionally, occupationally, physically, etc.) Use the back of this sheet if necessary. _____

_____

_____

_____

_____

_____

Key Questions:

1a. In your relationships with others, what is the one thing you desire most?

_____

_____

_____

_____

1b. How do you respond when you don't get it?

_____

_____

_____

_____

Question 2: Since scheduling your appointment, how have events been different, better, or worse?

_____

_____

_____

_____

Thank you for choosing
Spirit Christian Counseling Center