

# Selah Biblical Counseling CLIENT INTAKE FORM

**Primary Client Name:**

**Street Address:**

**City:**

**State:**

**Zip:**

**Home Phone**

**Work**

**Mobile**

**May we call you at your... home? work? mobile?**

**May we leave a voicemail? yes no**

**Email:**

**Birthdate: Age: Gender: male female**

**Occupation:**

**Education Level:**

**Spouse's Education Level:**

**Marital Status:**

**Name of Spouse:**

**Marriage Date:**

**Please list any other immediate family members:**

Name	Age	Relationship to you

**If you have been married before, please list those marriages:**

Previous Spouse's Name	Marriage 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 the following:

Counselor's Name	Problem	Duration	Results

## THOUGHTS AND BEHAVIORS

How often do the following thoughts occur to you?

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

Please comment (with examples, frequency, duration, effects on you) about each of the thoughts and behaviors that occur frequently or are a concern to you:

Enter information here if there wasn't room elsewhere:

## EMERGENCY CONTACT

Who should we contact in case of an emergency?

Name:

Address:

Home Phone:

Mobile Phone:

For office use:

Therapist:

Diagnostic code:

Date of first session: fee:

Insurance Carrier: Y N