Forever Ministries

Intake Form

The following form, which will become a part of your confidential record, will enable us to gain a quicker understanding of you. Please answer each question as completely and carefully as you can.

Name: _____ Date of Birth _____ Age:_____ Sex:____

Present Address: _____
Number *Street*

_____
City *County* *State* *Zip Code*

Home Phone: _____ Cell Phone: _____ Social Security # ___/___/_____

Presently living with: Parents _____ Spouse _____ Roommate _____ Alone-Other _____

Marital Status: Single _____ Married _____ (# of years _____) Divorced _____ Separated _____

Occupation _____ Total hours/week _____

Employed by _____ Phone: _____

Years of education _____ Religious Affiliation _____

Church _____ Active _____ Inactive _____

Family member to notify in case of emergency: Name: _____

Address: _____ Phone: _____

Referred by _____

FAMILY MEMBERS

Relationship	Name	Age	Grade in school last completed	Occupation if out of school
Spouse				
Father				
Mother				
Brother (s)				
Sister (s)				
Children				

Intake Form (Confidential)

Describe any physical problems that you have that require medication or physical care: _____

_____

Are you currently receiving medial treatment? Yes _____ No _____

Are you currently taking any prescription drugs? Yes _____ No _____ If yes, please list: _____

_____

Previous Counseling / Therapy Yes _____ No _____ If yes, when? _____

Where and with whom? Name: _____

Address: _____

In your own words, briefly describe the main problem that prompted you to seek counseling at this time:

_____

_____

_____

Have there been times when the problem got better or disappeared? Yes _____ No _____

If so, when? _____

What do you think helped? _____

_____

Were there times when the problem was especially bad? Yes _____ No _____

What made it bad? _____

_____

Are there people who play a major role in:

1. Causing your problem? Yes _____ No _____
2. Helping you to cope with your problem? Yes _____ No _____

Explain briefly: _____

Current symptoms (last 3-6 months)

No Appetite Feeling Panicy Difficulty Making Decisions Nightmares Overeating Depressed Mood
Low Self-esteem Alcohol/Drug Use Feeling Lonely Insomnia Sexual Problems Impulsiveness
Suicidal Thoughts Unable to Work Oversleeping Headaches Feeling Tense Fatigue Stomach Trouble
Unable to Relax Difficulty Making Friends Shakiness Dizziness

Therapeutic Goals:

Personal Strengths:

Personal Limitations:

Intake Form (Confidential)

Do you have any history of abuse (physical, sexual, emotional or spiritual?

_____

Is there anything else that you believe might be important for your counselor to know at this time?

_____

Problem Are: In the following list, place a check mark next to each item that identifies an area of concern to you. Place two checks by those items that are most important. (You may add comments after areas checked.)

_____ Anger
_____ Depression
_____ Education
_____ Eating difficulties
_____ Fearfulness
_____ Financial problems
_____ Marital problems
_____ Physical problems
_____ Problems with social relationships
_____ Problems with children
_____ Problems with parents
_____ Religious/Spiritual Concern
_____ Sexual concerns
_____ Thoughts of suicide
_____ Trouble making decisions
_____ Unhappy most of the time
_____ Use of alcohol
_____ Use of alcohol by family member
_____ Use of drugs
_____ Work
_____ Worry
_____ Other (specify) _____

I have read the Information Sheet and voluntarily request counseling services in accord with terms described on the information sheet.

Signature: _____

Date: _____

For clients age 17 and under, the signature of his/her guardian or custodial parent is required.

Signature: _____

Date: _____