CROSSINGS COMMUNITY CHURCH

LifeCare Ministry – Counseling

CLIENT INTAKE FORM

Client's Last Name: _____ First Name: _____

Date of Birth: _____ Male: _____ Female: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone(s) Home: _____ Cell: _____ Work: _____ May We Leave Message? _____

Email(s): _____ 2nd _____

Reason(s) for seeking counseling

_____

_____

_____

_____

On a scale of 0-5, rate your feelings and thoughts: (0= none, 5=excessive)

Feelings:		Thoughts:	
Helpless _____	Anxious_____	Confused _____	Racing _____
Depressed _____	Out of Control _____	Unintelligent _____	Obsessive _____
Shameful _____	Afraid _____	Worthless _____	Distracted _____
Angry _____	Numb _____	Unmotivated _____	Disorganized _____
Guilty _____	Relaxed _____	Unattractive _____	Paranoid _____
Hopeless _____	Happy _____	Unlovable _____	Suicidal _____
Lonely _____	Excited _____	Confident _____	Sensitive _____
Sad _____	Hopeful_____	Worthwhile _____	Honest _____
Stressed _____	Inferiority Feeling _____	Homicidal _____	
Unhappy _____	Mood Shifts _____		

FAMILY MEMBERS LIVING AT HOME

SPOUSE Name _____ Birth Date: _____

	Name	Birth Order	Age / DOB	With Whom Do They Live	Bio/Step/Adopt
CHILDREN	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

EMPLOYMENT INFORMATION

Employer's Name: _____ Your Position: _____

Address: _____ City: _____ State: _____ Zip: _____

CHURCH INFORMATION

Do you regularly attending Crossings? _____ Yes _____ No If yes, for how long? _____

If so, please indicate activities in which you are involved:

Worship Service: 9:30 10:45 11:00 Crossings School: _____

SS Class: _____ Other: _____

CareSeries Monday Night Class: _____

What other church(s) do you attend? _____

_____

Who referred you to Crossings LifeCare Ministries? _____

BACKGROUND

Are you: Single _____ Dating _____ Married/Co-Habitating _____ Divorced _____ Widowed _____

If applicable, rate your relationship with your current partner (place an X on the line below).

_____

Major Problems Minor Problems Satisfactory Very Satisfactory

How long have you been in the relationship? _____ Previous Marriages: _____1 _____2 _____3

Any DHS/Protective Services Intervention? _____ Yes _____ No

If yes: Date: _____ Cause: _____

Disposition: _____

Family background

- Number of Brothers ☐ Their ages: ☐ ☐ ☐ ☐
- Number of Sisters ☐ Their ages: ☐ ☐ ☐ ☐
- Birth Order: ☐ In a Family of: ☐

  (Are you the oldest sibling, youngest, etc.)

Were you adopted or raised with parents other than your natural parents? _____ Yes _____ No

Explain: _____

_____

Briefly describe the following:

Your Mother's Personality: _____

Your Father's Personality: _____

Your Stepparent's Personality: _____

MEDICAL HISTORY

Please list any significant past or current health, medical or psychiatric issues (including anything resulting in hospitalizations).

Dates	Problem & Treatment	Hospitalized? (Y/N)

Have you **seen or are you currently seeing**, a psychiatrist, psychologist, therapist, or counselor? Yes __No __

Reason	Therapist	When?	Helpful? (Y/N)

Consider a typical week during the **past month**. Please fill in a number for each day of the week indicating the typical number of drinks you usually consume on that day and the typical number of hours you usually drink on that day.

1 Drink = 12 oz. beer
4 oz. of wine
1 oz. of hard alcohol (regular shot glass)

	Su	M	T	W	Th	F	Sa
Number of drinks							
Number of hours							

Think of the occasion that you drank the most in the past month. How much did you drink? _____

How many hours did you drink? _____

If applicable, amount of caffeinated beverages per day: coffee _____ soda _____ espresso _____ tea _____

If applicable, number of cigarettes smoked per day: ___ If applicable, how often do you use marijuana per week? ___

If applicable, other substances used: _____

Medications

Current Prescribed Medications	Dose	Dates	Purpose	Side Affects

Current over-the-counter Medications, Vitamins or Herbs	Dose	Dates	Purpose	Side Affects

I understand the above information to be true.

Signed _____ Date _____