Providence Church
Counseling Intake Form

Today's Date: _____

Name: _____ Date of Birth: _____ Age: _____

Address: _____City _____State _____Zip_____

Primary Phone: (_____)_____ Cell____ Home ___ Work ____

Other phone: (_____)_____ Cell____ Home ___ Work ____

Is it alright to leave a message? _____

Email (only if you would like to use this as a form of communication): _____

Occupation _____ Place of Employment_____

Marital Status:

( ) Single ( ) Married *year* _____ ( ) Divorced *year* _____ ( ) Remarried *year* _____

( ) Engaged ( )Widowed *year* _____

Spouse's Name: _____

Spouse's Occupation: _____ Place of Employment: _____

Children:

Name	Gender	Age	Relationship	Living in Home	Grade/occupation

Briefly describe/explain the presenting problem(s):

_____

_____

_____

Briefly explain what has been tried to resolve the problem(s):

_____

_____

_____

Please list any counseling/therapy you have sought, past or present:

_____

_____

_____

Please list any medications you are currently taking:

_____

_____

Presenting Problems

Please check the following that apply to you. I have had or have problems with <u>thoughts</u> of:

_____ Not being good enough
_____ Not being cared about
_____ Not belonging/fitting in
_____ Being understood
_____ Being rejected
_____ Being abandoned
_____ Being a failure
_____ Being unattractive
_____ Being overweight
_____ Hopelessness
_____ Not knowing my identity
_____ Hearing voices or sounds inside my head
_____ Hearing voices or sounds that others can't or don't hear
_____ Seeing things or people that others can't or don't see
_____ Having special powers
_____ Being superior or privileged
_____ Being in danger
_____ Being followed or spied on
_____ Revenge/getting even
_____ Racing ideas
_____ Being a bad or evil person
_____ Flashbacks of past trauma
_____ Hurting or killing myself
_____ Hurting or killing others
_____ Sexual preoccupation
_____ Excessive religiosity
_____ Nightmares
_____ Something medically wrong
_____ Impending doom or death

Please check the following that apply to you. I have had or have problems with <u>feelings</u> of:

_____ Guilt
_____ Apathy/indifference
_____ Boredom
_____ Intense loneliness
_____ Intense sadness
_____ Helplessness
_____ Depression
_____ Irritability
_____ Intense frustration
_____ Anger
_____ Hate
_____ Rage
_____ Tension
_____ Being under pressure
_____ Being out of control
_____ Anxiety/apprehension
_____ Specific fears/phobias
_____ Intense excitement/euphoria
_____ Obsessive love/infatuation
_____ Mistrust/suspiciousness

Please check the following that apply to you. I have had or have problems with <u>behaviors</u> of:

_____ Aggression/fighting
_____ Stealing
_____ Vandalism
_____ Fire setting
_____ Injuring self
_____ Suicidal acts
_____ Bossing/controlling others
_____ Using drugs/alcohol
_____ Gambling
_____ Sex/sex related
_____ Child abuse and/or neglect
_____ Eating
_____ Sleeping
_____ Inefficiency
_____ Avoidance
_____ Forgetting
_____ Lying
_____ Impulsiveness
_____ Being oppositional
_____ Sadistic Acts
_____ Homicidal acts
_____ Attention/concentration
_____ Achievement
_____Being too dependent
_____ Perfectionism
_____ Smoking
_____ Taking the blame
_____ Making decisions
_____ Procrastinating
_____Arguing
_____ Temper
_____ Running away
_____ Rebellious
_____ Self-defeating acts
_____ Helping others too much
_____ Irresponsibility
_____ Being taken advantage of

Other problems with:

_____ Spiritual or religion
_____ Relationships
_____ Financial
_____ Marital
_____ Family
_____ Parenting
_____Job-related School/education related
_____ Financial Physical/medical related