

CHRISTIAN COUNSELING ASSOCIATES

A MINISTRY OF CORNERSTONE LODGE, INC.
INTAKE SHEET

COUNSELEE INFORMATION

Primary Client _____

Last Name First Name MI Nickname

Address _____

Street City State Zip

Home Phone _____ Work _____ Cell _____

Email _____

Date of Birth _____ Age _____ Gender _____

Occupation _____

May we call you at your home? Yes No

May we call you at your office? Yes No

May we call you on your cell? Yes No

May we leave a message at your home? Office? Cell?

Current Marital Status:

Never Married Married Engaged Divorced

Separated Widowed

Name of Spouse (if applicable) or Parents (if client is a minor) _____

Date of Marriage _____

Name of other family members:

_____ Age _____ Gender _____ Relationship _____

_____ Age _____ Gender _____ Relationship _____

_____ Age _____ Gender _____ Relationship _____

_____ Age _____ Gender _____ Relationship _____

_____ Age _____ Gender _____ Relationship _____

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 (if applicable):

SELF:

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

Name of Previous Spouse	Date of Marriage	Date of Divorce/Death
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_____	_____	_____
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_____	_____	_____
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_____	_____	_____
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For office use:

Therapist: _____

Diagnostic code: _____

Date of first session: _____ fee _____

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? _____

Do you have a personal relationship with Christ? ____ 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? _____

Would you like prayer as part of your counseling? ____ Yes ____ No

Who referred you to our center? _____

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

Do you have addictive/abusive issues with: ____ Alcohol ____ Illegal Drugs ____ Prescriptions

____ Sex ____ Pornography ____ Gambling ____ Other: _____

Has your appetite or weight changed lately? _____

Are you currently on medication? ____ Yes ____ No

If so, please complete the following:

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

PERSONAL CONCERNS

Briefly explain why you are coming to counseling and what you hope to gain from your experience. _____

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:

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? _____

