

# 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
_____	_____	_____
_____	_____	_____
_____	_____	_____

SPOUSE:

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

For office use:

Therapist: \_\_\_\_\_

Diagnostic code: \_\_\_\_\_

Date of first session: \_\_\_\_\_ fee \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Y or N

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## 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? \_\_\_\_\_

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?

\_\_\_\_ Very Healthy \_\_\_\_ Healthy \_\_\_\_ Average \_\_\_\_ Needs Improvement \_\_\_\_ Poor

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

\_\_\_\_ Sex \_\_\_\_ Pornography \_\_\_\_ Gambling \_\_\_\_ Gaming \_\_\_\_ 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? \_\_\_\_\_

## THOUGHTS AND BEHAVIORS

Please check how often the following thoughts occur to you:

- |                                |                          |       |                          |        |                          |           |                          |            |
|--------------------------------|--------------------------|-------|--------------------------|--------|--------------------------|-----------|--------------------------|------------|
| 1. Life is hopeless.           | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Frequently |
| 2. I am lonely.                | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Frequently |
| 3. No one cares about me.      | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Frequently |
| 4. I am a failure.             | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Frequently |
| 5. Most people don't like me.  | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Frequently |
| 6. I want to die.              | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Frequently |
| 7. I want to hurt someone.     | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Frequently |
| 8. I am so stupid.             | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Frequently |
| 9. I am going crazy.           | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Frequently |
| 10. I can't concentrate.       | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Frequently |
| 11. I am so depressed.         | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Frequently |
| 12. God is disappointed in me. | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Frequently |
| 13. I can't be forgiven.       | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Frequently |
| 14. Why am I so different?     | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Frequently |
| 15. I can't do anything right. | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Frequently |
| 16. People hear my thoughts.   | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Frequently |
| 17. I have no emotions.        | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Frequently |
| 18. Someone is watching me.    | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Frequently |
| 19. I hear voices in my head.  | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Frequently |
| 20. I am out of control.       | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Frequently |

Please rate the following symptoms on a scale of 0-2:

0 = Not significant/Non-existent    1 = Moderate/Sometimes    2 = Frequent/Severe

- |                                    |                          |  |                          |
|------------------------------------|--------------------------|--|--------------------------|
| Excessive anger, easily frustrated | <input type="checkbox"/> | Hyperactivity                                  | <input type="checkbox"/> |
| Mood swings (depression-manic)     | <input type="checkbox"/> | Change or loss of friends                      | <input type="checkbox"/> |
| Excessive guilt or shame           | <input type="checkbox"/> | Sexual problems                                | <input type="checkbox"/> |
| Loss of energy                     | <input type="checkbox"/> | Self-mutilation, cutting                       | <input type="checkbox"/> |
| Loss of interest in activities     | <input type="checkbox"/> | Excessive stress                               | <input type="checkbox"/> |
| Suicidal thoughts                  | <input type="checkbox"/> | Anxiety or excessive fears                     | <input type="checkbox"/> |
| Suicide attempts (how many)        | <input type="checkbox"/> | Learning disabilities                          | <input type="checkbox"/> |
| Lying                              | <input type="checkbox"/> | Work or school related problems                | <input type="checkbox"/> |
| Manipulation                       | <input type="checkbox"/> | Hallucinations, delusions, thought distortions | <input type="checkbox"/> |
| Poor impulse control               | <input type="checkbox"/> | Obsessive thoughts &/or compulsive behaviors   | <input type="checkbox"/> |

Please comment (e.g., examples, frequency, duration, effects on you) about each of the above thoughts/behaviors that occur frequently or are a concern to you.

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## EMERGENCY CONTACT

Whom should we contact in case of emergency?

Name \_\_\_\_\_  
 Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_