TrueNorth Christian Counseling
Intake Form

Please fill in the following information. Give accurate and complete responses to every section of this form. If necessary, write additional information in the margins.

Date _________________

Your name ____Age____

Spouse's name ____Age____

Children's names ____ Age____

____ Age____

____ Age____

____ Age____

Street Address ____

City ________________________________State______ Zip Code __________________

Phone _____________________________ Cell Phone _____________________________

Email _____________________________ Referral from ___________________________

Is it OK to leave a message on an answering machine? (Circle answer)

At work? Yes No At home? Yes No

Is it OK to leave a message with a family member? Yes No

Permission to Text? Yes No

In case of emergency, whom may we contact? Name: _______________________________

Emergency contact's phone # (other than your own home #) _________________________

Relationship to client: ____

Counseling History

Have you or your family ever received counseling for any reason? Yes ___ No ___

When? ________________ what reason? ____

Reason for seeking counseling now:

____
____
____
____

How long have you been experiencing this difficulty?

____

Are you presently working with any other Counselor or Psychiatrist? Yes ___ No___

What reason? ____ how long? ______________

Counselor / Agency ____

Family History

Identify and describe your primary female caregiver (mother, relative, step mother) as you remember her during your life at home. List some of her characteristics as a person.

____
____
____

Identify and describe your primary male caregiver (father, relative, step father) as you remember him during your life at home. List some of his characteristics as a person.

____
____
____

How did your parents or caregivers get along with each other while you were in the home?

____
____

Describe any significant problems between you and your brothers and sisters:

____
____
____

List any relatives with a history of emotional or mental disorder or suicide (include diagnosis and treatment if known)

____
____
____

Relatives with a history of alcoholism or excessive alcohol or drug use:

____

____

List any significant past trauma experienced by you or those close to you (i.e., death, divorce, sickness, crime, etc.)

____

____

____

Religious History

In what religious faith were you raised? ____

Present affiliation or name of church you attend? ______________________________________

Have you accepted Jesus as your Lord and Savior? Yes _______ No _______ Unsure _______

If yes, when did you accept Him? _____________________________

Have your religious experiences and training helped or hurt your ability to deal with your struggles? ____

How often do you read your Bible? ____

Do you have a regular time to pray? ____

Have you had any unusual "religious experiences"? ____ Yes _____ No If yes, please explain:

____

Check any losses that you have experienced:

__ Death of a Spouse

__ Child

__ Father

__ Mother

__ Sister

__ Brother

__ Grandmother

__ Grandfather

__ Aunt or uncle

__ suicide

__ miscarriage

__ abortion

__ adoption

__ infertility

__ bankruptcy

__ homelessness

__ career or job loss

__ Divorce

__ Other ____

Check any concerns or issues you have now or in the past:

NOW - PAST

____ ____ Alcohol
____ ____ Academic issues
____ ____ Parent-child communication
____ ____ Attention deficient Hyperactivity disorder
____ ____ Peer pressure
____ ____ Suicidal thoughts __ suicidal attempt___ suicidal threat___
____ ____ Drugs ____
____ ____ Prescription Drugs ____________________________________
____ ____ binge eating, excessive dieting or exercise, purging
____ ____ shopping
____ ____ working too much
____ ____ procrastination
____ ____ communication
____ ____ depression
____ ____ anger / rage
____ ____ grief
____ ____ anxiety
____ ____ sexual abuse ___ Physical abuse ___ emotional abuse___ verbal ____
____ ____ gender identity
____ ____ sex
____ ____ pornography
____ ____ career
____ ____ loneliness
____ ____ mood swings
____ ____ low self esteem __ self hatred _____
____ ____ co – dependency
____ ____ stress
____ ____ fear ____
____ ____ negative or troubling feelings about church or God
____ ____ cutting or self injury
____ ____ addiction ____

General Information

MEDICAL:
Physician: ____City ____________
Date last seen: ____________________________ Reason _______________________
Ongoing medical concerns: ____
Allergies: ____
Medication(s) ____

LEGAL: Current _____________ Previous ____________ N/A ___________
Charges _____________________________ Probation? ________________________
Court district ____

EDUCATION:
Highest – grade achieved: _________________
Name of College or Vocational school: _______________________________________
Year of Graduation ____________ Graduate school ____________________________

MILITARY:
Dates of service __________________ Branch ____________________ Rank _________
Type of discharge ____
How were your relationships with peers? _____________________________________
With supervisors? ____

WORK HISTORY
Are you satisfied with your present occupation? ________________________________
How long have you been with your present company? ____________________________
Are you satisfied with your present income level? _______________________________

DAILY ROUTINE
How is your appetite? __________ Any changes in the last six months? ____________
Recent weight loss or gain? _____________
How well do you sleep? ________________________Any changes in the last six months ____
Fall asleep OK? _________________________ Stay asleep? _______________________
Describe your exercise habits.
____
____

CLIENT CONSENT TO TREATMENT

I have read and received the Informed Consent and completed the Intake form.

_________________________ ________

Client # 1 Name (please print) Date

_________________________ ________

Client # 2 Name (please print) Date

_________________________ ________

Parent / Guardian Signature Date

_________________________ _______

Counselor / Therapist Signature Date