*FMB Christian Counseling*

Adult Intake Form

Instructions: Please complete the survey as accurately as possible, including any information that you feel could benefit the counseling process. All information contained in this survey is confidential except as prohibited by state / federal law regarding major criminal offenses and child, elderly, or disabled persons abuse.

PERSONAL INFORMATION

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Mailing Address City / State / Zip Code

Telephone: (home) \_\_\_\_\_\_\_\_\_\_\_\_\_ (work) \_\_\_\_\_\_\_\_\_\_\_\_\_ (cell) \_\_\_\_\_\_\_\_\_\_\_\_

Email address:

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name of Company

Current Profession: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status \_\_ Single \_\_ Married \_\_Divorced

 \_\_ Remarried \_\_ Widowed

Children (You do not need to include child’s name):

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

gender / age / currently living in the home gender / age / currently living in the home

2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

gender / age / currently living in the home gender / age / currently living in the home

3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

gender / age / currently living in the home

**EMERGENCY INFORMATION**

In case of an emergency contact:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Mailing Address City / State / Zip Code

Telephone:(home) \_\_\_\_\_\_\_\_\_\_\_\_\_ (work) \_\_\_\_\_\_\_\_\_\_\_\_\_ (cell) \_\_\_\_\_\_\_\_\_\_\_\_

**REASON FOR SEEKING COUNSELING**

What specific issue(s) in your life are your hoping will be addressed through the counseling process? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Continued: Page 2

# FAMILY BACKGROUND

**Parents:**

Are your parents living?

Father: Yes \_\_\_\_\_ No \_\_\_\_\_ Your age at time of death: \_\_\_\_\_

Mother: Yes \_\_\_\_\_ No \_\_\_\_\_ Your age at time of death: \_\_\_\_\_

Are they Living Together? Yes \_\_\_\_\_ No \_\_\_\_\_

Divorced? Yes \_\_\_\_\_ No \_\_\_\_\_ How old were you when they divorced? \_\_\_\_\_

Remarried?

Father: Yes \_\_\_\_\_ No \_\_\_\_\_ Your age at time of remarriage: \_\_\_\_\_

Mother: Yes \_\_\_\_\_ No \_\_\_\_\_ Your age at time of remarriage: \_\_\_\_\_

Was your relationship with your mother: close \_\_\_\_\_ distant \_\_\_\_\_conflicted \_\_\_\_\_

Was your relationship with your father: close \_\_\_\_\_ distant \_\_\_\_\_conflicted \_\_\_\_\_

Siblings (You do not need to include siblings’ name):

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 gender / age gender / age

2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_5) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 gender / age gender / age

3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 gender / age

Where do you fall in the birth order? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How was your relationship with your siblings growing up?

Close \_\_\_\_\_ Distant \_\_\_\_\_ Conflicted \_\_\_\_\_

Was yours a basically happy or unhappy home during childhood?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were there any instances of abuse in your family?

 By Whom? Abuse Directed Toward?

Verbal Yes\_\_\_\_\_ No \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emotional Yes \_\_\_\_\_ No \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical Yes\_\_\_\_\_ No \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexual Yes \_\_\_\_\_ No \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol Yes \_\_\_\_\_ No \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Including substance abuse)

Other problems not mentioned \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Continued: Page 3

**SPIRITUAL HISTORY**

Note: The counseling provided will be conducted from a faith based perspective. While the counselee does not have to be of the Christian faith they understand that issues of faith will be an important component of the counseling process.

What is your religious or church background? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently active in your church? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you describe your relationship with God? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# MOOD INVENTORY

Do you have any of the following symptoms:

 Yes No

1. Change in eating habits (poor appetite/overeat)? \_\_ \_\_

2. Change in sleeping patterns (insomnia/oversleeping)? \_\_ \_\_

3. Have a lack of motivation/energy for ordinary tasks? \_\_ \_\_

4. Have feelings of hopelessness? \_\_ \_\_

5. Have poor concentration and difficulty making decisions? \_\_ \_\_

6. Have you ever been diagnosed with:

 depression \_\_ \_\_

 schizophrenia \_\_ \_\_

 obsessive compulsive disorder \_\_ \_\_

 attention deficit disorder \_\_ \_\_

 anxiety disorder \_\_ \_\_

 bipolar \_\_ \_\_

 other (please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Have you personally ever received psychiatric

 treatment? \_\_ \_\_

1. Has any member of your family ever received psychiatric

treatment? If yes, who and what was the diagnosis: \_\_ \_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. Feel mentally confused? \_\_ \_\_

10. Self medicate (through alcohol, sex, food, work,

 entertainment, etc.)? \_\_ \_\_

11. Have short term memory loss? \_\_ \_\_

12. Have panic attacks? \_\_ \_\_

13. Hear voices in your head? \_\_ \_\_

14. Are you now undergoing psychiatric treatment? \_\_ \_\_

15. Are you currently on medications? \_\_ \_\_

 If so, which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Continued: Page 4

# ADDICTION INVENTORY

Have you ever felt you had/have a problem with any of the following:

 Currently In the Past

 alcohol Yes \_\_\_\_\_ No \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

 substances Yes \_\_\_\_\_ No \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

 tobacco Yes \_\_\_\_\_ No \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

 food Yes \_\_\_\_\_ No \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

 gambling Yes \_\_\_\_\_ No \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

 pornography Yes \_\_\_\_\_ No \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

 sex Yes \_\_\_\_\_ No \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

 other (please list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has anyone in your family been addicted to any of the above?

If so, which ones and by whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# PERSONAL INVENTORY

Describe yourself in as many one or two word phrases as possible:

1) 6)

2) 7)

3) 8)

4) 9)

5) 10)

# ADDITIONAL INFORMATION

Please describe any additional information that you feel is important to the counseling process.

# FEE INFORMATION

Fees for counseling services are required at the time of the appointment. The standard fee is $75.00 per session. If a reduced rate or financial assistance is being requested, a Reduced Rate, Sliding Scale and Benevolence Fund application is required. The number of sessions available for reduced rate clients may be limited.

There is a $3.75 per transaction fee for all credit card payments. Cancellations not made 24 hours in advance may result in a $55.00 cancellation fee.

Signature Printed Name

Date