Grace Redeemer Church Counseling Intake Form

Personal Information

Date: _____

First Name: _____ Last Name: _____

Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Date of Birth: _____ Sex: ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Significant Relationship ☐ Engaged ☐ Married ☐ Divorced ☐ Living Together

Highest Level of Education: ☐ Grade School ☐ High School ☐ Some College ☐ College Grad ☐ Graduate Degree

Occupation: _____

How did you hear about us?: _____

Do you currently attend or are a member of a church? ☐ Yes ☐ No If yes, which church?

_____

If you are not currently attending church, would you be interested in speaking to someone about Grace Redeemer Church or being follower of Christ? ☐ Yes ☐ No

Presenting Problems and Concerns

Describe your current concern(s) and what you hope to address in counseling:

_____

_____

_____

How long has it been an issue? _____

What steps have you taken to address this issue?

_____

_____

Please check all of the behaviors and symptoms that you consider problematic as it relates to yourself *(select all that apply)*:

- ☐ Difficulty concentrating
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Boredom
- ☐ Poor memory
- ☐ Phobias
- ☐ Compulsive behaviors
- ☐ Hopelessness
- ☐ Self-harm behaviors
- ☐ Guilt/Shame
- ☐ Eating problems
- ☐ Relationship problems
- ☐ Visual hallucinations
- ☐ Other: _____
- ☐ Change in appetite
- ☐ Lack of motivation
- ☐ Isolation
- ☐ Anxiety/Worry
- ☐ Panic attacks
- ☐ Obsessive thoughts
- ☐ Sadness/Depression
- ☐ Helplessness
- ☐ Loneliness
- ☐ Fatigue
- ☐ Flashbacks
- ☐ Work/School problems
- ☐ Anger
- ☐ Paranoia
- ☐ Racing thoughts
- ☐ Too much energy
- ☐ Mood swings
- ☐ Social discomfort
- ☐ Sleep problems
- ☐ Loss of pleasure
- ☐ Thoughts of death
- ☐ Low self-esteem
- ☐ Nightmares
- ☐ Alcohol/Drug use
- ☐ Hearing voices
- ☐ Hypersensitivity

Are your problems affecting any of the following?

- ☐ Work/School
- ☐ Hygiene/Ability to care for self
- ☐ Finances
- ☐ Health
- ☐ Self-esteem
- ☐ Housing
- ☐ Recreational Activities
- ☐ Everyday tasks/Functioning
- ☐ Relationships
- ☐ Legal matters
- ☐ Sexual activity
- ☐ Ability to care for others (dependents)

Have you ever had thoughts, made statements/gestures, or attempted to hurt yourself? ☐ Yes ☐ No If yes, pls describe:

Have you ever had thoughts, made statements/gestures, or attempted to hurt someone else or property? ☐ Yes ☐ No
If yes, pls describe:

Do you have access to weapons? ☐ Yes ☐ No If yes, please explain: _____

Do you have: ☐ Current ☐ Past ☐ Pending Legal Charges (restraining order, etc)? ☐ Yes ☐ No If yes, pls explain:

How would you describe your religious background and your current beliefs about God?

Past/Present Counseling/Therapy

Describe any services you have or are receiving:

Begin Date: _____ End Date: _____ Estimated number of sessions: _____

Initial reason for counseling:

How helpful was the counseling/therapy? _____

Reason for ending? _____

Family Background (if never married, skip this section)

Name of Spouse: _____

Spouse's Occupation: _____

Living with you now? ☐ Yes ☐ No Is your spouse willing to come to counseling (if applicable)? ☐ Yes ☐ No

Date of Marriage: _____ How long did you know your spouse before marriage? _____

Are there any previous marriages? ☐ Yes ☐ No

Give brief information about any previous marriage(s):

_____

_____

List name(s), gender(s) & age(s) of your children:

_____

_____

Any foster/adoptive children? ☐Yes ☐No Any history of miscarriages, abortions or difficulties with fertility? ☐Yes ☐No

Family History

Is your mother still living? ☐ Yes ☐ No Mother's age (if living)? _____

Mother's health? ☐ Good ☐ Fair ☐ Bad Quality of relationship with your mother:

_____

Is your father still living? ☐ Yes ☐ No Father's age (if living)? _____

Father's health? ☐ Good ☐ Fair ☐ Bad Quality of relationship with your father:

_____

Rate your parents' marriage: ☐ Unhappy ☐ Average ☐ Happy ☐ Very Happy

Rate your childhood life: ☐ Unhappy ☐ Average ☐ Happy ☐ Very Happy

Have you had any abusive or extremely difficult experiences in your life or family? ☐ Yes ☐ No

How many brothers and sisters do you have? _____ Where are you in the birth order of your siblings? _____

Rate your relationship with your siblings: ☐ Unhappy ☐ Average ☐ Happy ☐ Very Happy

Medical Background

Rate your physical health: ☐ Very Good ☐ Good ☐ Average ☐ Declining ☐ Other

List current medicine(s) prescribed to you:

Medication	Dosage	Date 1st Prescribed	Prescribed by	Reason

Allergies and/or adverse reactions to medication? ☐ Yes ☐ No If yes, please list:

Please list past and present medical conditions (e.g., allergies, seizures, chronic disease, sleep issues, etc.):

Describe any surgeries, other hospitalizations, injuries or limitations:

Substance Use History

Substance Type	Current Use (last 6 months)				Past Use				
	Yes	No	Frequency	Amount	Yes	No	Age at initial use	Frequency	Years Used
Tobacco	☐	☐			☐	☐			
Caffeine	☐	☐			☐	☐			
Alcohol	☐	☐			☐	☐			
Marijuana	☐	☐			☐	☐			
Cocaine/Crack	☐	☐			☐	☐			
Ecstasy	☐	☐			☐	☐			
Heroin	☐	☐			☐	☐			
Inhalants	☐	☐			☐	☐			
Methamphetamines	☐	☐			☐	☐			
Pain Killers	☐	☐			☐	☐			
LSD	☐	☐			☐	☐			
PCP	☐	☐			☐	☐			
Steroids	☐	☐			☐	☐			
Benzodiazepines	☐	☐			☐	☐			
Other:	☐	☐			☐	☐			

Have you had withdrawal symptoms when trying to stop using any substances? ☐ Yes ☐ No If yes, please describe:

Have you ever had problems with work, relationships, health, legal consequences, etc., due to substance use? ☐ Yes ☐ No

If yes, please describe:

Is there anything else you would like to tell us on this questionnaire?

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