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My Father's House Christian Counseling Services, LLC
(985) 710-1202

Client Intake Form

Client Information:

Today's Date: ___/___/___ Client's Name: _____
Phone Numbers: (Home) _____ (Work) _____ (Cell) _____
Can we call you at work? Yes / No
Address: _____
City: _____ State: _____ Zip _____
Age: ____ Birth Date: ___/___/___
Marital Status:[ ] Single [ ] Engaged
[ ] Married – How Long? _____ - How many times? _____
[ ] Separated – How Long? [ ] Divorced – How long? _____
Education: _____ Occupation: _____
Place of Employment: _____

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Counseling History:

Briefly describe the reason(s) you are seeking counseling: _____
_____
What is your most difficult relationship right now? _____
What is your most difficult emotion right now? _____
Who is coming for counseling? _____
Have you had any previous counseling? ____ If yes, when? _____
Where / With Whom? _____ Why? _____
Are you, or a family member, currently seeing a psychiatrist or another counselor? _____
If so, what family member? _____ Psychiatrist / Counselor Name: _____
For what reason? _____

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Crisis Information:

Are you currently having suicidal thoughts, feelings, or actions? Yes / No
If yes, explain: _____
Are you currently homicidal / assaultive thoughts or feelings, or anger-control problems? Yes / No If yes, explain: _____
Have you had any past problems, hospitalizations, incarcerations for suicidal or assaultive behavior? Yes / No If yes, explain: _____
Are you currently experiencing any current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)? Yes / No
If yes, describe: _____
Emergency Contact Information (name, relationship, phone number, address):
_____
_____
_____

Client's Name: _____

Medical Information:

When were you last examined by a physician? _____
Name of physician: _____ Phone: _____
Address: _____
List any medical conditions you are currently being treated for: _____
_____
List any medications you are currently taking:

Name of Medication	Frequency Taken	Reason for Medication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you enter into therapy with me, may I tell your medical doctor so that he / she can be fully informed and we can coordinate your treatment? Yes / No

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Complete this section if client is under the age of 18.

Parent / Guardian's Name: _____
Phone Numbers: (Home) _____ (Work)_____ (Cell)_____ (Beeper) _____
Can we call you at work? Yes / No
Age: ____ Birth Date: ___/___/___ Marital Status:[ ] Single [ ] Engaged
Education: _____ Place of Employment: _____

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Spouse's Name: _____

Phone Numbers: (Home)_____ (Work)_____ (Cell)_____ Can we call him / her at work? Yes / No
Address: _____
Age: ____ Birth Date: ___/___/___
Marital Status:[ ] Single [ ] Engaged
[ ]Married – How Long? _____ - How many times? _____
[ ] Separated – How Long? _____ [ ] Divorced – How long? _____
Education: _____
Occupation: _____
Place of Employment: _____

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Client's Children:

List name, birth date, sex, relationship of all children, and whether they live at home with you.

Name	Birth Date	Sex	Relationship	At Home?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Client's Name: _____

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Client's Family of Origin:

Father: First Name _____ Age ____ Occupation _____
State of Health _____ Resides in _____
If deceased, how and when _____
List 3 words that best describes him (ex: loving, mean, etc.) _____
_____
How do / did you get along with him? _____
Mother: First Name _____ Age ____ Occupation _____
State of Health _____ Resides in _____
If deceased, how and when _____
List 3 words that best describes her (ex: loving, mean, etc.) _____
_____
How do / did you get along with her? _____
Stepfather: First Name _____ Age ____ Occupation _____
State of Health _____ Resides in _____
If deceased, how and when _____
List 3 words that best describes him (ex: loving, mean, etc.) _____
_____
How do / did you get along with him? _____
Stepmother: First Name _____ Age ____ Occupation _____
State of Health _____ Resides in _____
If deceased, how and when _____
List 3 words that best describes her (ex: loving, mean, etc.) _____
_____
How do / did you get along with her? _____

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Brothers and Sisters: Please list in birth order.

Name	Age	Sex	Where Reside	Relationship With Client (close / distant / in between)

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Have you ever experienced any of the following:
[ ] Harsh physical punishment or abuse as a child
[ ] Sexual advances made toward you as a child
[ ] Sexual abuse
[ ] Incest
[ ] Rape
[ ] Physical abuse by spouse or lover
[ ] Verbal or emotional abuse as a child or adult
If so, please explain:

Substance Use/Abuse History (N/A is not applicable)

Substance	First Use	Last Use	Current Use
Depressants			
Alcohol	_____	_____	_____
Inhalants	_____	_____	_____
Barbiturates	_____	_____	_____
Hallucinogens	_____	_____	_____
Marijuana	_____	_____	_____
LSD	_____	_____	_____
Mushrooms	_____	_____	_____
PCP	_____	_____	_____
Stimulants	_____	_____	_____
Amphetamines	_____	_____	_____
Cocaine	_____	_____	_____
Crack(freebase)	_____	_____	_____
Other	_____	_____	_____

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Client's Religion / Faith:

Religious Affiliation during childhood: _____

Religious Affiliation now: _____

Level of meaningfulness of religious affiliation during childhood and adolescence:
High Medium Low

Level of meaningfulness or religious affiliation now:
High Medium Low

Attached is a Client Information Form which outlines the counseling policies and related information with a consent to treatment. Please read these forms, discuss any concerns, sign, and return them to me. If you have any questions regardinging fees or other issues, please ask.

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This is a strictly confidential client record.

Client's Signature: _____ Date __/___/___

_____ Date __/___/___

Referral Information: Who referred you to me for counseling?

Name: _____ Phone: _____

May I have your permission to thank this person for the referral? Yes / No