CONFIDENTIAL INTAKE FORM

GENERAL INFORMATION

Date: _____ Referred by: ❑ Northland ❑UCF ❑ Friend ❑ Previous OCC Client ❑_____

Full name: _____ Name you prefer: _____

Ethnicity: ❑ Asian ❑Biracial/bicultural ❑ Black/African American ❑Caucasian ❑ Hispanic/Latino ❑Other

Sex: ❑ Male ❑ Female Date of birth: _____ Age: _____

Street address: _____ Suite/Apartment #: _____

City: _____ State: _____ Zip code: _____
May we send mail here: ❑ Yes ❑ No

Home Phone: _____ Call you here? ❑ Yes ❑ No Message here? ❑ Yes ❑ No

Work phone: _____ Call you here? ❑ Yes ❑ No Message here? ❑ Yes ❑ No

Cell phone: _____ Call you here? ❑ Yes ❑ No Message here? ❑ Yes ❑ No

Email: _____ Contact you here? ❑ Yes ❑ No

Employer: _____ How long have you been there: _____

Occupation: _____ Average hours worked per week: _____

Highest level of education completed: _____ Are you currently in school? ❑ Yes ❑ No

If yes, what level? _____ Degree pursuing: _____

Are you a student or immediate family member of a student of The Reformed Theological Seminary? _____

Do you regularly attend a place of worship? ❑ Yes ❑No. If yes, where? _____

In case of emergency, contact:

Name: _____ Relationship: _____

Home phone: _____ Cell phone: _____

RELATIONAL INFORMATION

Relationship status: ❑ Single ❑ Dating ❑ Engaged ❑ Married ❑ Separated ❑ Divorced

❑Cohabitating and unmarried ❑Partnered ❑Unsure ❑ Widowed

How long have you been that status? _____

Number of previous marriages for you? _____ For your partner/spouse? _____

Partner's/Spouse's name: _____ Partner's/Spouse's age: _____

Is your partner/spouse supportive of you seeking counseling? ❑ Yes ❑ No ❑ Unsure ❑ He/She doesn't know

With whom do you currently live? (*Check all that apply*) ❑ Alone ❑ Spouse ❑ Children ❑Parent(s) ❑Sibling(s)
❑ Boyfriend ❑ Girlfriend ❑ Roommate ❑ Other: _____

List your children (including step, adopted, foster, deceased) below:

Name	Sex	Age or year of death	Relationship to you	Living with whom?

Have you ever placed a child for adoption? ❑ Yes ❑ No. If Yes, when? _____

Have you ever had a ❑ miscarriage or ❑ medical abortion? ❑ Yes ❑ No. If Yes, when? _____

List your mother, father, brothers, sisters, step-family relations, or any other family member who had a significant effect (positive or negative) upon your life.

Name	Age or year of death	Relationship to you (e.g., mother, father, sibling, step-relation)	Give 2-3 words to describe this person

COUNSELING HISTORY

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the names of the therapists or programs: *(Use the back, if necessary*)

Therapist's name or program	Major issue(s)	Dates/Number of Sessions

MEDICAL HISTORY

List any medical conditions, illnesses, treatments, or surgeries:
_____
_____
_____

Your height: _____ your weight: _____

How has your weight changed in the last 2-3 months: ❑ little or no change ❑ up _____lbs. ❑ down _____ lbs.

List all current medications you are taking, including those you seldom use or take only as needed:
(Use back if necessary)

Doctor & Name of medication	Dose	Reason for taking medication

Are you presently experiencing any suicidal thoughts? ❑ Yes ❑ No
Have you experienced them in the past? ❑ Yes ❑ No Have you ever attempted suicide? ❑ Yes ❑ No
If Yes, when and how: _____

Have any of your ❑ friends or ❑ family ever committed or attempted suicide? ❑ Yes ❑ No
If yes, when and who: _____

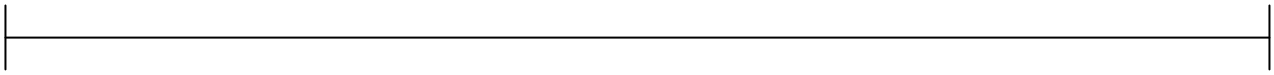
Are you presently experiencing any thoughts of harming yourself or another person? ❑Yes ❑No

PRESENT ISSUES

Check any of the following symptoms or problems that you are presently experiencing or have experienced in the past.

Present	Past		Present	Past		Present	Past	
❑	❑	Stress	❑	❑	Fears	❑	❑	Controlled by others
❑	❑	Anxiety or worry	❑	❑	Shyness	❑	❑	Obsessive thoughts
❑	❑	Panic	❑	❑	Low self-esteem	❑	❑	Compulsive behaviors
❑	❑	Depression	❑	❑	Don't like myself	❑	❑	Seeing things others don't see
❑	❑	Crying all the time	❑	❑	Marital problems			
❑	❑	Lack of motivation	❑	❑	Other relational problems	❑	❑	Hearing voices
❑	❑	Fatigue/Lack of energy	❑	❑	Parenting problems	❑	❑	Racing thoughts
❑	❑	Poor appetite or overeating	❑	❑	Physical abuse	❑	❑	Eating problems
❑	❑	Trouble sleeping	❑	❑	Emotional abuse	❑	❑	Drug use
❑	❑	Poor concentration	❑	❑	Verbal abuse	❑	❑	Alcohol use
❑	❑	Feeling worthless or inferior	❑	❑	Sexual abuse	❑	❑	Pregnancy
❑	❑	Feeling hopeless	❑	❑	Sexual problems	❑	❑	Abortion
❑	❑	Guilt	❑	❑	Gender identity	❑	❑	Legal matters
❑	❑	Death of friend or loved one	❑	❑	Anger	❑	❑	Work stress
❑	❑	Grief	❑	❑	Aggressive behavior	❑	❑	Career choices
❑	❑	Chronic pain	❑	❑	Bad dreams	❑	❑	Indecisiveness
❑	❑	Physical disability	❑	❑	Unwanted memories	❑	❑	Lack of discipline
❑		Terminal illness	❑	❑	Loss of control	❑	❑	Financial problems
❑	❑	Health concerns	❑	❑	Impulsive behavior	❑	❑	Spiritual apathy
❑	❑	Loneliness	❑	❑	Controlling	❑	❑	Other_____

Please use an "X" on the scale below to indicate how distressing your problem(s) are to you.



Minimally Distressing — Moderately Distressing — Extremely Distressing

Please describe why you are coming to counseling *(i.e., what are your issues, problems?)*:

_____

_____

Why have you decided to come for counseling now?

_____

_____

What do you hope to gain or change by coming for counseling?

_____

_____

How will you know you accomplished your goals?

_____

_____

TERMS OF SERVICE

I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of intention to cancel, I will be charged the full administrative fee for service.

Signed: _____ Date: _____