CHRISTIAN COUNSELING ASSOCIATES

A MINISTRY OF CORNERSTONE LODGE, INC.

INTAKE SHEET

CLIENT INFORMATION

Primary Client _____
Last Name First Name MI Nickname

Address _____
Street City State Zip

Home Phone _____ Work _____ Cell _____

Email _____

Date of Birth _____ Age _____ Gender _____

Occupation _____

May we call you at your home? _____ Yes _____ No

May we call you at your office? _____ Yes _____ No

May we call you on your cell? _____ Yes _____ No

May we leave a message at your home? _____ Office? _____ Cell? _____

Current Marital Status:
___ Never Married ___ Married ___ Engaged ___ Divorced ___ Separated ___ Widowed

Name of Spouse (if applicable) or Parents (if client is a minor)_____

Date of Marriage _____

Name of other family members:

_____ Age ____ Gender ____ Relationship _____

_____ Age ____ Gender ____ Relationship _____

_____ Age ____ Gender ____ Relationship _____

_____ Age ____ Gender ____ Relationship _____

_____ Age ____ Gender ____ Relationship _____

Your Education Level: ___ GED ___ High School Diploma

___ College Degree ___ Graduate Degree Degree In _____

Spouse's Education Level: ___ GED ___ High School Diploma

___ College Degree ___ Graduate Degree Degree In _____

For office use:
Therapist: _____
Diagnostic code: _____
Date of first session: _____ fee _____

Previous Marital History (if applicable):

SELF:

Name of Previous Spouse	Date of Marriage	Date of Divorce/Death
_____	_____	_____
_____	_____	_____
_____	_____	_____

SPOUSE:

Name of Previous Spouse	Date of Marriage	Date of Divorce/Death
_____	_____	_____
_____	_____	_____
_____	_____	_____

PERSONAL INFORMATION

Are you currently attending a church? ____ Yes ____ No

If yes, what is the name of the church? _____

What is the denomination of the church? _____

Do you have a personal relationship with Christ? ____ Yes ____ No ____ Unsure

Are religious or spiritual issues important in your life? ____ Yes ____ No

Are you aware of any religious or spiritual resources in your life that could be used to help you overcome your problems? ____ Yes ____ No

If yes, what are they? _____

Would you like prayer as part of your counseling? ____ Yes ____ No

Who referred you to our center? _____

May we contact them? ____ Yes ____ No

How would you rate your health? _____

How many hours do you sleep each night? _____

How would you rate your diet?

___ Very Healthy ___ Healthy ___ Average ___ Needs Improvement ___ Poor

Do you have addictive/abusive issues with: ___ Alcohol ___ Illegal Drugs ___ Prescriptions

___ Sex ___ Pornography ___ Gambling ___ Gaming ___ Other: _____

Has your appetite or weight changed lately? _____

Are you currently on medication? ____ Yes ____ No

If so, please complete the following:

Medication	Dosage	Physician	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PERSONAL CONCERNS

Briefly explain why you are coming to counseling and what you hope to gain from your experience.

_____

_____

How much are you troubled by this?

____ Constantly ____ Often ____ Somewhat ____ Not Very Much

Comments concerning this problem: _____

_____

Have you been in counseling before? ____ Yes ____ No

If so, for each incidence you remember, please complete the following:

1. Who was the counselor? _____

   What was the problem? _____

   How many sessions over what period of time? _____

   What were the results? _____

2. Who was the counselor? _____

   What was the problem? _____

   How many sessions over what period of time? _____

   What were the results? _____

3. Who was the counselor? _____

   What was the problem? _____

   How many sessions over what period of time? _____

   What were the results? _____

THOUGHTS AND BEHAVIORS

Please check how often the following thoughts occur to you:

1.	Life is hopeless.	____ Never	____ Rarely	____ Sometimes	____ Frequently
2.	I am lonely.	____ Never	____ Rarely	____ Sometimes	____ Frequently
3.	No one cares about me.	____ Never	____ Rarely	____ Sometimes	____ Frequently
4.	I am a failure.	____ Never	____ Rarely	____ Sometimes	____ Frequently
5.	Most people don't like me.	____ Never	____ Rarely	____ Sometimes	____ Frequently
6.	I want to die.	____ Never	____ Rarely	____ Sometimes	____ Frequently
7.	I want to hurt someone.	____ Never	____ Rarely	____ Sometimes	____ Frequently
8.	I am so stupid.	____ Never	____ Rarely	____ Sometimes	____ Frequently
9.	I am going crazy.	____ Never	____ Rarely	____ Sometimes	____ Frequently
10.	I can't concentrate.	____ Never	____ Rarely	____ Sometimes	____ Frequently
11.	I am so depressed.	____ Never	____ Rarely	____ Sometimes	____ Frequently
12.	God is disappointed in me.	____ Never	____ Rarely	____ Sometimes	____ Frequently
13.	I can't be forgiven.	____ Never	____ Rarely	____ Sometimes	____ Frequently
14.	Why am I so different?	____ Never	____ Rarely	____ Sometimes	____ Frequently
15.	I can't do anything right.	____ Never	____ Rarely	____ Sometimes	____ Frequently
16.	People hear my thoughts.	____ Never	____ Rarely	____ Sometimes	____ Frequently
17.	I have no emotions.	____ Never	____ Rarely	____ Sometimes	____ Frequently
18.	Someone is watching me.	____ Never	____ Rarely	____ Sometimes	____ Frequently
19.	I hear voices in my head.	____ Never	____ Rarely	____ Sometimes	____ Frequently
20.	I am out of control.	____ Never	____ Rarely	____ Sometimes	____ Frequently

Please rate the following symptoms on a scale of 0-2:

0 = Not significant/Non-existent 1 = Moderate/Sometimes 2 = Frequent/Severe

1. Excessive anger, easily frustrated ____
2. Mood swings (depression-manic) ____
3. Excessive guilt or shame ____
4. Loss of energy ____
5. Loss of interest in activities ____
6. Suicidal thoughts ____
7. Suicide attempts (how many) ____
8. Lying ____
9. Manipulation ____
10. Poor impulse control ____
11. Hyperactivity ____
12. Change or loss of friends ____
13. Sexual problems ____
14. Self-mutilation, cutting ____
15. Excessive stress ____
16. Anxiety or excessive fears ____
17. Learning disabilities ____
18. Work or school related problems ____
19. Hallucinations, delusions, thought distortions ____
20. Obsessive thoughts & or compulsive behaviors ____

Please comment (e.g., examples, frequency, duration, effects on you) about each of the above thoughts/behaviors that occur frequently or are a concern to you.

_____

_____

_____

_____

_____

_____

_____

_____

_____

EMERGENCY CONTACT

Whom should we contact in case of emergency?

Name _____

Address _____

Home Phone _____ Cell Phone _____