NEW BEGINNINGS COUNSELING CENTER

Intake Form

The following form, which will become a part of your confidential record, will enable us to gain a quicker understanding of you. Please answer each question as completely and as carefully as you can. Please use the bottom of the last page for any additional information or comments.

Name____ **Date of Birth**__________ **Age**____ **Sex**__________

Present Address____**Phone**____________________________
Number Street

____**Cell Phone**__________________________
City State Zip Code

____
Email address

Marital Status: Single_____ Married_____ (# of Years_____) Divorced_____ Separated ______ Widowed______

Presently Living With: Parents____ Spouse____ Roommate____ Alone____ Other______________________________

Family Member to notify in case of Emergency:

Name____________________________________**Address**____

Phones____**Relationship**_________________________

Occupation: ____**Total Hours worked per week**____________________

Employed by:______________________________________ **Years of Education:** ______**Phone**_________________

Referred by: ____

Religious Affiliation_____________________________ **Pastors Name** ____

Active Member______ Inactive Member______ Church You Attend _____________________________________

Members of Current Household: (living with you in the same house)

Relationship	Name	Age	Last Grade Completed	Occupation
________________	______________________________	______	__________________	______________________
________________	______________________________	______	__________________	______________________
________________	______________________________	______	__________________	______________________
________________	______________________________	______	__________________	______________________
________________	______________________________	______	__________________	______________________
________________	______________________________	______	__________________	______________________

Describe any physical problems you have that require medication or physical care:_____________________________

____

Are you currently receiving medical treatment? _______ **If so, Doctors name:** __________________________________

Health Info: ____

Are you currently taking medications?________ **Please list Medications**____

____

Previous Counseling/Therapy? _____**If yes, when?**____

Where & with whom?____

Name **Title**

____

Address **Phone**

Please list your parents (living or deceased) and any brothers or sisters:

Relationship	Name	Age	Last Grade in School	Occupation	How often do you see them?

In your own words, briefly describe the main problem which prompted you to seek counseling at this time.

____

____

Have there been times when the problem got better or disappeared? Yes _____**No**______

If so, when?____

Were there times when the problem was especially bad? Yes _____**No**______ **Explain**______________________________

____

Please list any persons you feel may have played a major role in causing your problems___________________________

____

Please list any person who helps you cope with your problems____

____

Please check the type of counseling you desire:

Individual____ **Pre-marital** ____ **Marital**____ **Child/Teen**_____ **Short Term Crisis** _____ **Family**_____ **Addiction** ____

Group_____ **Divorce Recovery**_____ **Grief/Loss** _____ **Illness** _____**Occult**_____ **Abuse**_____ **Domestic Violence**_____

Anger Management ____ **Stress Management** ____ **Sexual Issues** _____ **Emotional Healing** _____ **Relationships** _____

Other____

Please make a check mark next to each item which identifies an area of concern for you. Place two checks by those items that are most important..

______Addictions (alcohol, drugs, food, gambling, sex, etc.)

______Anger

______Depression

______Education/Learning Difficulties

______Eating Difficulties

______Fearfulness/Anxiety/Panic Attacks

______Marital Problems

______Health/Physical Problems

______Problems with social relationships

______Financial Problems

______Mental Health Problems

______Problems with children

______Problems with parents

______Religious/Spiritual Concerns

______Sexual Concerns

______Thoughts of Suicide

______Trouble making Decisions/confusion

______Unhappy most of the time

______Addiction of a family member

______Work/Job related

______Worry

______Other (Specify)_________________________

I, ________________________________(print your name), have read the policy sheet, completed the intake form, and have submitted to counsel of my own free will. I recognize that the counselors of New Beginnings Counseling Center are Pastoral Counselors and may approach me with Christian or Biblical concepts and prayer. I will not hold New Beginnings Counseling Center, nor its staff, responsible for the outcome of therapy. (It is my choice to follow the counsel or not)

____ ______________________________

Signature **Date**

For clients 17 years and under, the signature of his/her guardian or custodial parent is required.

____ ______________________________

Signature of Parent or Guardian **Date**

Comments or further information: