Plum Creek Christian Church
COUNSELING CENTER
Bettie Howe, LPCC
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CLIENT INTAKE FORM

Today's Date: _____

A. Client's Name _____ Age _____ Birth Date _____

Parent/Guardian's Name(s) _____ Ages _____

Address _____

Street City State Zip

Phone (Home)_____ (Work)_____ (Cell) _____

Email: _____

Marital Status _____ Education _____

Occupation _____

Spouse's Name _____ Age _____

Spouse's Education _____ Spouse's Occupation _____

Person to contact in an emergency (name, relationship, phone, address) _____

_____

B. List name, age, sex, and relationship of persons in household:

NAME	AGE	RELATIONSHIP

C. Who is coming for counseling? _____ Any prior counseling? Yes ☐ No ☐

If yes, please list the following information:

Date	Name of Therapist or Institution	Nature of Problem	Result of Treatment

Are you, or any other family member, currently seeing a psychiatrist or another therapist? Yes ☐ No ☐

If so, what family member? _____ Name of helper? _____

For what purpose? _____

PLEASE FILL OUT THE FOLLOWING INFORMATION AS IT APPLIES TO THE CLIENT

D. State the nature of the problem in your own words: _____

_____

_____

What is your most difficult relationship right now? _____

What is your most difficult emotion right now? _____

E. **CRISIS INFORMATION:** *Any current suicidal thoughts, feelings, or actions?* Yes ☐ No ☐

If yes, please explain: _____

Any current homicidal or assaultive thoughts or feelings, or anger-control problems? Yes ☐ No ☐

If yes, please explain: _____

Any past problems, hospitalizations, or jailings for suicidal or assaultive behavior? Yes ☐ No ☐

If yes, please explain: _____

Any current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)? Yes ☐ No ☐

If yes, please explain: _____

F. **SPIRITUAL INFORMATION:** Do you believe Jesus is the son of God? Yes ☐ No ☐ Not sure ☐

How close to God do you feel? ***Separated*** ***Sort of Close*** ***Very Close***

0 1 2 3 4 5 6 7 8 9 10

What churches, if any, have you attended?

Church or Denomination	**Attended at what age?**
_____	_____
_____	_____
_____	_____

G. **MEDICAL INFORMATION:**

_____

Doctor's Name City Phone number

Are you presently taking any medication? Yes ☐ No ☐ If so, please list the following information:

Name	Dosage	Results
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any problems with eating? ☐ Sleeping? ☐ Chronic pain? ☐ Recent weight change? ☐

Explain any answers checked above: _____

Any other medical problems? Yes ☐ No ☐ If so, explain: _____

Have you or any family member ever been hospitalized for mental/emotional illness? Yes ☐ No ☐

If yes, please explain - who, dates, place, reason: _____

_____

H. How did you hear about the Counseling Center? _____

THANK YOU for taking the time to fill out this information sheet. Your counselor will review this with you in the first session and use it to best assist you in your counseling work. We will maintain your strict confidence regarding this information, subject to the exceptions noted in your service agreement. Be sure to review and sign the elements of your service agreement.