

# CROSSINGS COMMUNITY CHURCH

## LifeCare Ministry – Counseling

### CLIENT INTAKE FORM

Client's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone(s) Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_ May We Leave Message? \_\_\_\_\_

Email(s): \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_

#### Reason(s) for seeking counseling

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On a scale of 0-5, rate your feelings and thoughts: (0= none, 5=excessive)

#### Feelings:

Helpless \_\_\_\_\_ Anxious \_\_\_\_\_  
Depressed \_\_\_\_\_ Out of Control \_\_\_\_\_  
Shameful \_\_\_\_\_ Afraid \_\_\_\_\_  
Angry \_\_\_\_\_ Numb \_\_\_\_\_  
Guilty \_\_\_\_\_ Relaxed \_\_\_\_\_  
Hopeless \_\_\_\_\_ Happy \_\_\_\_\_  
Lonely \_\_\_\_\_ Excited \_\_\_\_\_  
Sad \_\_\_\_\_ Hopeful \_\_\_\_\_  
Stressed \_\_\_\_\_ Inferiority Feeling \_\_\_\_\_  
Unhappy \_\_\_\_\_ Mood Shifts \_\_\_\_\_

#### Thoughts:

Confused \_\_\_\_\_ Racing \_\_\_\_\_  
Unintelligent \_\_\_\_\_ Obsessive \_\_\_\_\_  
Worthless \_\_\_\_\_ Distracted \_\_\_\_\_  
Unmotivated \_\_\_\_\_ Disorganized \_\_\_\_\_  
Unattractive \_\_\_\_\_ Paranoid \_\_\_\_\_  
Unlovable \_\_\_\_\_ Suicidal \_\_\_\_\_  
Confident \_\_\_\_\_ Sensitive \_\_\_\_\_  
Worthwhile \_\_\_\_\_ Honest \_\_\_\_\_  
Homicidal \_\_\_\_\_

### FAMILY MEMBERS LIVING AT HOME

**SPOUSE** Name \_\_\_\_\_ Birth Date: \_\_\_\_\_

<b>CHILDREN</b>	Name	Birth Order	Age / DOB	With Whom Do They Live	Bio/Step/Adopt
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

**EMPLOYMENT INFORMATION**

Employer's Name: \_\_\_\_\_ Your Position: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**CHURCH INFORMATION**

Do you regularly attending Crossings? \_\_\_\_ Yes \_\_\_\_ No If yes, for how long? \_\_\_\_\_

If so, please indicate activities in which you are involved:

Worship Service: 9:30 10:45 11:00 Crossings School: \_\_\_\_\_

SS Class: \_\_\_\_\_ Other: \_\_\_\_\_

CareSeries Monday Night Class: \_\_\_\_\_

What other church(s) do you attend? \_\_\_\_\_

Who referred you to Crossings LifeCare Ministries? \_\_\_\_\_

**BACKGROUND**

Are you: Single \_\_\_\_ Dating \_\_\_\_ Married/Co-Habiting \_\_\_\_ Divorced \_\_\_\_ Widowed \_\_\_\_

If applicable, rate your relationship with your current partner (place an X on the line below).

Major Problems \_\_\_\_\_ Minor Problems \_\_\_\_\_ Satisfactory \_\_\_\_\_ Very Satisfactory \_\_\_\_\_

How long have you been in the relationship? \_\_\_\_\_ Previous Marriages: \_\_\_\_1 \_\_\_\_2 \_\_\_\_3

Any DHS/Protective Services Intervention? \_\_\_\_ Yes \_\_\_\_ No

If yes: Date: \_\_\_\_\_ Cause: \_\_\_\_\_

Disposition: \_\_\_\_\_

**Family background**

- Number of Brothers  Their ages:
- Number of Sisters  Their ages:
- Birth Order:  In a Family of:

(Are you the oldest sibling, youngest, etc.)

Were you adopted or raised with parents other than your natural parents? \_\_\_\_ Yes \_\_\_\_ No

Explain: \_\_\_\_\_

**Briefly describe the following:**

Your Mother's Personality: \_\_\_\_\_

Your Father's Personality: \_\_\_\_\_

Your Stepparent's Personality: \_\_\_\_\_

## MEDICAL HISTORY

Please list any significant past or current health, medical or psychiatric issues (including anything resulting in hospitalizations).

Dates                      Problem & Treatment    Hospitalized? (Y/N)


Have you **seen or are you currently seeing**, a psychiatrist, psychologist, therapist, or counselor? Yes \_\_ No \_\_

Reason    Therapist    When?    Helpful? (Y/N)


Consider a typical week during the **past month**. Please fill in a number for each day of the week indicating the typical number of drinks you usually consume on that day and the typical number of hours you usually drink on that day.

1 Drink = 12 oz. beer  
               4 oz. of wine  
               1 oz. of hard alcohol (regular shot glass)

	Su	M	T	W	Th	F	Sa
Number of drinks							
Number of hours							

Think of the occasion that you drank the most in the past month. How much did you drink? \_\_\_\_\_

How many hours did you drink? \_\_\_\_\_

If applicable, amount of caffeinated beverages per day:    coffee \_\_\_\_\_    soda \_\_\_\_\_    espresso \_\_\_\_\_    tea \_\_\_\_\_

If applicable, number of cigarettes smoked per day: \_\_\_\_    If applicable, how often do you use marijuana per week? \_\_\_\_

If applicable, other substances used: \_\_\_\_\_

### Medications

Current Prescribed Medications	Dose	Dates	Purpose	Side Affects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter Medications, Vitamins or Herbs	Dose	Dates	Purpose	Side Affects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

***I understand the above information to be true.***

Signed \_\_\_\_\_ Date \_\_\_\_\_