

THE JOY COUNSELING CENTER - CONFIDENTIAL CLIENT INTAKE FORM

GENERAL INFORMATION

Date: _____ Referred by: _____

Full Name: Mr. Mrs. Ms. Miss Dr. Rev. _____

Nickname: _____ Name You Prefer: _____

Social Security: _____ Age: _____ Date of Birth: _____

Race: White Black Hispanic Asian Other: _____ Sex: Male Female

CONTACT INFORMATION

Street Address: _____ Suite/Apartment Number: _____

City: _____ State: _____ Zip Code: _____ May We Send Mail Here: Yes No

Mailing Address or Post Office Box: _____

City: _____ State: _____ Zip Code: _____ May We Send Mail Here: Yes No

Home Phone: (_____) _____ May We Leave a Message Here: Yes No

Mobile Phone: (_____) _____ May We Leave a Message Here: Yes No

Work Phone: (_____) _____ May We Leave a Message Here: Yes No

Email Address: _____ May We Send Email Here: Yes No

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: (_____) _____ Mobile Phone: (_____) _____

EMPLOYMENT INFORMATION

Employer: _____ Length of Employment: _____

Occupation: _____ Average Hours Worked Per Week: _____

Average Annual Salary: \$0 to \$10,000 \$20,001 to \$40,000 \$50,001 to \$60,000 \$80,001 to \$100,000
 \$10,001 to \$20,000 \$40,001 to \$50,000 \$60,001 to \$80,000 More than \$100,000

EDUCATION INFORMATION

Last Year of School Completed: 9 10 11 12 GED College: 1 2 3 4 Other: _____

Are You Currently in School: Yes No. If Yes, What Level: _____ Degree Pursuing: _____

RELATIONAL INFORMATION

Current Relational Status: Single Dating Engaged Married Separated Divorced Widowed

Are You Content with Your Current Status: Yes No. If No, Briefly Explain: _____

If Married, How Long: _____ Number of Previous Marriages for You: _____ For Your Partner: _____

If Separated or Divorced, How Long: _____ If Widowed, How Long: _____

Partner's Name: Mr. Mrs. Ms. Miss Dr. Rev. _____

How Long Have You Known Your Partner: _____ Age: _____ Preferred Name: _____

Partner's Race: White Black Hispanic Asian Other: _____ Partner's Sex: Male Female

Partner's Occupation: _____ Average Hours Worked Per Week: _____

Last Year of School Partner Completed: 9 10 11 12 GED College: 1 2 3 4 Other: _____

What Words Would You Use to Describe Your Partner: _____

Is Your Partner Supportive of You Seeking Counseling: Yes No Unsure Partner Doesn't Know

With Whom Do You Currently Live (*Check All that Apply*): Alone Spouse Children Parent(s) Sibling(s)
 Boyfriend Girlfriend Roommate Other: _____

CHILDREN

List Your Children (Living or Deceased):

Name	Sex	Current Age or Year of Death	Relationship to You <i>(e.g. Natural, Adopted, Step)</i>	Living with You?	Describe Him/Her

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: _____

FAMILY OF ORIGIN

List Mother, Father, Brothers, Sisters, Step Family, and Any Other Family Members who Effected You Positively or Negatively:

Name	Sex	Current Age or Year of Death	Relationship to You <i>(e.g. Mom, Dad, Sibling, Step)</i>	Occupation	Describe Him/Her

MEDICAL INFORMATION

Primary Physician: _____ Phone: (_____) _____

Address: _____ City: _____ Zip: _____

Specialty (e.g. Family Practice, OB/GYN, Internal Medicine): _____

Are You Currently Receiving Medical Treatment: Yes No. If Yes, Please Specify: _____

List Any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas or Related Treatments You Have Had (Use Back if Necessary): _____

MEDICATIONS

List All Current Medications You Are Taking, Including those You Seldom Use or Take Only as Needed (Use Back if Necessary):

Medication: _____ Dosage: _____ Improves Prevents Controls: _____

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Are You Taking these Medication(s) According to Your Doctor's Recommendations: Yes No

If No, Briefly Explain: _____

PHYSIOLOGICAL SYMPTOMS

Please Check Any of the Following Physiological Symptoms/Sensations that Apply to You Presently, or in the Recent Past:

- | | | |
|---|---|---|
| Headaches..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Dizziness..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Stomach Trouble.... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Visual Trouble..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Sleep Trouble..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Trouble Relaxing.... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Weakness..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Tension..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Rapid Heart Rate... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Difficulty Breathing.. <input type="checkbox"/> Past <input type="checkbox"/> Present | Intestinal Trouble.... <input type="checkbox"/> Past <input type="checkbox"/> Present | Hearing Noises..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Change in Appetite. <input type="checkbox"/> Past <input type="checkbox"/> Present | Tiredness..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Pain..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Hearing Voices..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Seeing Things..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Other..... <input type="checkbox"/> Past <input type="checkbox"/> Present |

Your Height: _____ Your Weight: _____ How has Your Weight Change in the Last 2-3 Months: _____

CURRENT STATUS

Please Check Any of the Following Problems which Pertain to You and/or Your Family:

- | | | |
|---|---|--|
| Stress..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Nervousness..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Anxiety..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Panic..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Unhappiness..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Depression..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Guilt..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Apathy..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Terminal Illness..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Recent Death..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Grief..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Hopelessness..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Inferiority Feelings.. <input type="checkbox"/> Past <input type="checkbox"/> Present | Defective Feelings.. <input type="checkbox"/> Past <input type="checkbox"/> Present | Loneliness..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Shyness..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Fears..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Friends..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Marriage..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Communication..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Physical Abuse..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Emotional Abuse.... <input type="checkbox"/> Past <input type="checkbox"/> Present | Verbal Abuse..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Sexual Abuse..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Temper..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Anger..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Aggressiveness..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Bad Dreams..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Concentration..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Racing Thoughts.... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Unwanted Thoughts <input type="checkbox"/> Past <input type="checkbox"/> Present | Memory..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Loss of Control..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Impulsive Behavior. <input type="checkbox"/> Past <input type="checkbox"/> Present | Self-Control..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Compulsivity..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Sexual Problems.... <input type="checkbox"/> Past <input type="checkbox"/> Present | Pregnancy..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Abortion..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Legal Matters..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Trauma..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Eating Problems.... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Drug Use..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Alcohol Use..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Trouble with Job.... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Career Choices..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Ambition..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Making Decisions... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Children..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Being a Parent..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Finances..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Recent Loss..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Disaster..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Other..... <input type="checkbox"/> Past <input type="checkbox"/> Present |

LEVEL OF DISTRESS

Indicate How Distressed You Are by Placing an "X" on the Scale Below (1 = Very Little Distress; 10 = Extreme Distress):

1 2 3 4 5 6 7 8 9 10

Are You Currently 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: _____

PRESENTING ISSUES AND GOALS

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 Long Do You Believe Counseling Should Last: _____

PREVIOUS COUNSELING

List Any Previous Counseling, Psychiatric Treatment, or Residential/In-Patient Care You Have Received (Use Back If Necessary):

Therapist: _____ Location: _____ Dates: _____ Reason: _____

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RELIGIOUS BACKGROUND

What Words Would You Use to Describe Yourself: _____

If God Were to Describe You, What Would He Say: _____

Briefly Describe the Religious Environment of Your Home as You Were Growing Up: _____

Complete the Following Thought: God Is _____

Do You Regularly Attend a Place of Worship: Yes No. If Yes, Where: _____

What Is the Name of Your Pastor, Priest, Rabbi, or Other Spiritual Leader: _____

Do You Have a Personal Support System: Yes No. If Yes, Who: _____

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: _____

