Holston Center for *Wellbeing*

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Conference Pastoral Counselor

Client Confidential Intake Information

Please carefully respond to questions

Name: _____ Date: _____

Street Address: _____ Date of Birth: _____

City/State: _____ Zip: _____

Email address:_____ Cell: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employment:_____

Referred by: _____

Permission to contact referral source to acknowledge that you followed up on your appointment?

☐ Yes ☐ No _____

Signature please

Religious affiliation: _____ Active? ☐ Yes ☐ No

Family – Please check those living in your home. Please mark **X** those who are deceased.

Current Spouse/partner_____	Age ____	Father _____	Age ___
Date of Marriage_____		Mother _____	Age ___
Children _____	Age ____	Siblings_____	Age ___
_____	Age ____	_____	Age ___
_____	Age ____	_____	Age ___
_____	Age ____	_____	Age ___
Others _____	Age ____	_____	Age ___
_____	Age ____	_____	Age ___

Prior Marriage(s)

If you have been previously married, please give the following dates and information:

First marriage from _____ to _____

Reasons ended: _____

_____

Second marriage from _____ to _____

Reasons ended: _____

_____

Third marriage from _____ to _____

Reasons ended: _____

_____

Spouse Prior Marriage(s)

If your present spouse has previous marriages please list the dates and information:

First marriage from _____ to _____

Reasons ended: _____

_____

Second marriage from _____ to _____

Reasons ended: _____

_____

Third marriage from _____ to _____

Reasons ended: _____

_____

Medical

Physician routinely seen: _____ Phone: _____

Specialty: _____ Address: _____

Current medications:_____

_____

Briefly describe any current medical problems: _____

_____

_____

☐ Check here if you would consent to consultation with primary care physician regarding your mental health.

Counseling or Therapy

Please discuss any previous counseling or therapy

_____ _____ _____

_____ _____ _____

_____ _____ _____

For Clergy Only:

Appointment history Level of Education _____

Charge **1** _____ Years _____

Reason for appointment change _____

_____

Charge **2** _____ Years _____

Reason for appointment change _____

Charge **3** _____ Years _____

Reason for appointment change _____

Charge **4** _____ Years _____

Reason for appointment change _____

Charge **5** _____ Years _____

Reason for appointment change _____

_____

Present Concerns

Please identify any that are of CONCERN TO YOU. Check all that apply.

☐ anger release/temper
☐ family problems
☐ marriage problems
☐ child rearing problems
☐ decision making
☐ work/job
☐ vocational discernment
☐ decision making
☐ eating/loss of appetite
☐ suicidal thoughts
☐ feelings of hopelessness
☐ feelings of helplessness
☐ feelings of worthlessness
☐ fear and anxiety
☐ general unhappiness
☐ religious/spiritual issues
☐ hearing/seeing things
☐ sleeplessness or too much sleep
☐ alcohol/drugs/tobacco
☐ finances
☐ friendships
☐ sexual concerns
☐ moving
☐ others (please list)
_____
_____
_____
_____
_____
_____

1. What is your MAIN reason for seeking counseling at this time?

_____

_____

_____

2. List several goals you would like to achieve through counseling:

3. Please describe any significant **problems** or **stressors** you are experiencing and for **how long**:

a. Mental or Emotional: _____
b. Family Relationships: _____
c. Work or School: _____
d. Health: _____
e. Legal Concerns: _____
f. Financial Pressures: _____

4. How would you rate your use of alcohol, tobacco, or drugs? List substances and how often.

_____

5. Do you suspect you misuse any prescription medications? _____

6. Are you concerned about your physical safety? Please explain: _____

_____

7. Please rate the following areas in your life: "**S**" for areas you are **S**atisfied or "**D**" for areas you are **D**issatisfied with:

_____Housing/Living Situation
_____Employment/Work Situation
_____Family Support
_____Spouse/Partner Support
_____Relationships with Friends
_____Ability to Care for Yourself
_____Education
_____Financial Situation

8. Family History: Please check the following problems that have occurred and note if occurred in: **a**) your immediate family, **b**) the family you grew up in, **c**) other relatives, or **d**) yourself.

☐ Substance abuse (alcoholism, drug abuse)	☐ Family "secrets"
☐ Other addictions	☐ Infidelity
☐ Sexual Abuse	☐ Chronic lying
☐ Physical Abuse	☐ Children out of wedlock
☐ Mental or emotional abuse	☐ Abortion
☐ Depression	☐ Divorce
☐ Suicide or attempted suicide	☐ Religious abuse
☐ Mental Illness	☐ Eating Disorders

9. What physical, mental or emotional SYMPTOMS have you experienced recently? Check all that apply.

☐ Muscle twitches	☐ Wish you could go to sleep and never wakeup
☐ Decrease in energy or fatigue	☐ Impaired memory (forget things more than usual)
☐ Hyperactivity	☐ Racing thoughts or speech
☐ Impulsiveness	☐ Tendency to go off on tangents
☐ Sexual problems	☐ Difficulty speaking
☐ Restlessness	☐ Racing heart
☐ Problems at work, school or academics	☐ Anxiety
☐ Over-aggressiveness	☐ Fear of abandonment
☐ Withdrawn from family or friends	☐ Panic attacks
☐ Stealing or dishonesty	☐ Excessive worry
☐ Destructiveness	☐ Flashbacks of distressing events
☐ Disorganization	☐ Phobias or excessive fears
☐ Trouble with authority figures	☐ Afraid of open spaces
☐ Breaking rules, pushing limits	☐ Nervousness
☐ Injuring self (such as cutting, pulling hair, etc.)	☐ Unsure of what is real
☐ Trouble with sleep (too much, too little, insomnia, etc.)	☐ Feel like you are outside your body watching yourself
☐ Anger or hostility	☐ Sometimes think you are hallucinating
☐ Apathy	☐ Obsessions, trouble getting thoughts out of your mind
☐ Depressed mood or lingering sadness	☐ Excessive fears of:_____
☐ Crying spells or tears come easily	☐ Concerns others are spying or trying to poison you
☐ Emotional highs	☐ Suicidal thoughts or wishes
☐ Feeling guilty	☐ Murderous thoughts or wishes
☐ Helplessness	☐ Eating disorder (starving, binging or purging)
☐ Hopelessness	☐ Emotional eating
☐ Irritability	☐ Unable to maintain normal weight
☐ Feelings of rejection	☐ Dissatisfied with body shape or weight
☐ Low self-esteem	☐ Concern over your use of alcohol or tobacco
☐ Reduced interest or enjoyment in life	☐ Concern over your use of drugs
☐ Noticeable mood swings	☐ Persistent desire for alcohol, tobacco or drugs
☐ Easily distracted	☐ Chronic Pain
☐ Difficulty making decisions	☐ Medical conditions:_____

Please fax this information\to Holston Center for Wellbeing
(865) 692-2393 or return to counselor by the second visit.