COVENANT
COUNSELING & CONSULTING

Client Intake Form | Page 1

Client's Name:

Birthday: (Month) (Day) (Year)

Age:

Gender:

List any *previous* marriages and length of marriage(s) if applicable:

If applicable, on the following scale, please rate your level of satisfaction with *your present* relationship:

Low ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **High**

Please list any children you have and their ages:

Please check ALL of the following symptoms or thoughts that apply to you AT THIS TIME or during the past six months:

- ☐ Depressed mood
- ☐ Diminished interests or pleasure
- ☐ Sleep disturbance
- ☐ Fatigue
- ☐ Change in appetite
- ☐ Hopelessness
- ☐ Pleasure in few activities
- ☐ Weight change
- ☐ Agitation
- ☐ Excessive worry
- ☐ I feel like I am losing control
- ☐ Irritability
- ☐ Poor concentration
- ☐ Tension
- ☐ Feelings of panic
- ☐ Socially withdrawn
- ☐ Use of alcohol
  - ☐ Daily
  - ☐ Weekly
  - ☐ Occasionally
- ☐ Use of tobacco
- ☐ Anxiety in social settings
- ☐ Makes careless mistakes
- ☐ Does not complete tasks
- ☐ Difficulty organizing
- ☐ Forgetful
- ☐ Confusion
- ☐ Disorientation
- ☐ Compulsive checking / counting
- ☐ Indecisiveness
- ☐ People talk about me
- ☐ Some people want to hurt me
- ☐ I feel emotionally distant from others
- ☐ I hear voices or sounds others do not hear
- ☐ I see things others do not see
- ☐ I smell things others do not smell
- ☐ Racing thoughts
- ☐ Use of other drugs
  - ☐ Cannabis ☐ LSD ☐ Opiates
  - ☐ Heroin ☐ MDMA ☐ Meth
  - ☐ Benzo ☐ Cocaine ☐ Other
- ☐ I do risky or dangerous things
- ☐ Little interest in sexual activity
- ☐ Sexual problems
- ☐ Gender concerns
- ☐ I don't like my body
- ☐ Binge eating
- ☐ Self-induced vomiting
- ☐ Laxative abuse
- ☐ Excessive fasting
- ☐ Intense fear of weight gain
- ☐ Impulsive
- ☐ I think about hurting myself
- ☐ I have tried to hurt myself
- ☐ Sometimes I wish I were dead
- ☐ I think about hurting someone else
- ☐ Exposed to a significant traumatic event
- ☐ Recurrent distressing dreams
- ☐ Other:

What issue / problem brings you to Covenant Counseling and Consulting (CCC)?

How long has this been an issue?

How is it that you are hoping we can help you? *(Your goal?)*

Please describe what, if anything, has been helpful to you in dealing with this problem:

To whom do you turn for emotional / social support?

Are you requesting cultural / religious considerations?

Have you previously been in counseling or treated in any way by a mental health professional? ☐ No ☐ Yes, with:

If so, was it a helpful experience?

IN THE PAST have you ever been prescribed medication for a psychological disorder? ☐ No ☐ Yes (please list:)

Have you ever received treatment for: ☐ Substance abuse ☐ Chronic pain

Are you CURRENTLY taking ANY prescription medication? ☐ No ☐ Yes (please list:)

GENERAL HEALTH INFORMATION

Your current weight: Height in inches:

Name of your primary care doctor: Phone: Date last seen:

Past Surgeries:

Do you have ANY health concerns you have not already addressed with a physician?

Have you ever received treatment for any of the following medical conditions?

- ☐ Neurological impairment
- ☐ Seizure disorder
- ☐ Visual loss / impairment
- ☐ Hearing loss / impairment
- ☐ Dementia
- ☐ GI disorder
- ☐ Obesity
- ☐ Significantly underweight
- ☐ Cirrhosis
- ☐ Hepatitis
- ☐ Heart condition
- ☐ Hypertension
- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic bronchitis
- ☐ Tuberculosis / +PPD
- ☐ Cancer
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Pregnancy
- ☐ Irregular menstrual periods
- ☐ Musculoskeletal condition
- ☐ HIV / AIDS / Related condition
- ☐ Eating disorders
- ☐ Other:

Have you been the victim of any of the following traumas? *(If yes, please provide a brief explanation:)*

Sexual abuse as a child ☐ No ☐ Yes:

Sexual assault ☐ No ☐ Yes:

Physical abuse ☐ No ☐ Yes:

Verbal or psychological abuse ☐ No ☐ Yes:

Witnessed the traumatic death or abuse of another person ☐ No ☐ Yes:

Head injury needing medical treatment ☐ No ☐ Yes:

Are you experiencing any legal issues?

Have you ever been arrested for a crime?

FAMILY HISTORY

In the section below identify ***if there is a family history*** of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, mother, grandmother, uncle, etc.) **If not sure, leave blank.** *Please note which family member had / has issue, if applicable.*

Alcohol / Substance Abuse ☐ No ☐ Yes:

Anxiety ☐ No ☐ Yes:

Depression ☐ No ☐ Yes:

Divorce / Marriage Problems ☐ No ☐ Yes:

Domestic Violence ☐ No ☐ Yes:

Eating Disorders ☐ No ☐ Yes:

Obsessive Compulsive Behavior ☐ No ☐ Yes:

Schizophrenia ☐ No ☐ Yes:

Suicide Attempts ☐ No ☐ Yes:

Bi-Polar Disorder ☐ No ☐ Yes:

Other mental health issues:

Additional Comments

I would describe my childhood as: ☐ Awful ☐ Disappointing ☐ Normal ☐ Good ☐ Ideal

My biological parents are: ☐ Married ☐ Separated ☐ Divorced ☐ Remarried

Father: ☐ Living ☐ Deceased ☐ Married ☐ Remarried ☐ times

Briefly describe your relationship with him: ☐ No relationship ☐ Strained ☐ Fair ☐ Good ☐ Very Good

Comment:

Mother: ☐ Living ☐ Deceased ☐ Married ☐ Remarried ☐ times

Briefly describe your relationship with her: ☐ No relationship ☐ Strained ☐ Fair ☐ Good ☐ Very Good

Comment:

Siblings *(Any connection or significance to your visit today?)*