

Scottsdale Bible Church
Counseling Ministry Intake Form

Folder Code _____

Today's Date ____/____/____

To enable the first session with your counselor to be more effective, you are asked to complete the following. Be assured that this information will be kept confidential. You will receive an initial intake by a counseling ministry staff person. At that time, it will be determined if you will be assigned to a Stephen Minister, Lay Counselor, Student Counselor, Professional Staff Counselor, Counseling/Support Group, or may be referred to a Professional in the community. Please use short answers and **PRINT legibly**.

Name _____ Date of Birth _____

Address _____ City _____ State ____ Zip _____

Home Phone _____ Work Number _____ Cell Phone _____

Please check if okay to leave a message at..... Home Work Cell Other _____

Emergency Contact: Name _____ Phone _____ Relationship _____

Primary Email Address: _____@_____

Employment: Self Other _____

How did you find the Counseling Ministry, or who referred you? _____

Status: Single Married Separated Divorced Remarried Widow(er) Living with _____

Years Married _____ Years Divorced _____ Months Together _____

Partner's Name _____ Their Date of Birth _____

Children's Names & Ages _____

Level of education: HS _____ College _____ Graduate Degree _____ Other _____

What church do you attend? _____ How often do you attend? _____

On a scale of 1 -10 how sure are you that if you died tonight that you would go to heaven? _____
(1 being not so sure -10 being absolutely positive)

Describe briefly your relationship with God _____

Describe any involvement in your life in cults or the occult _____

Describe your religious upbringing _____

Describe any specific religious/spiritual values/beliefs that you now hold _____

What hobbies, if any, do you have? _____

What do you do for recreation, physical activity? _____

Do you smoke? _____ How much? _____

Please list any past or present alcohol or drug use and amounts _____

Are you concerned about your current drug or alcohol use? Yes No

Do you know of anyone else who is concerned about your current drug or alcohol use? Yes No

How would you rate your current physical health? Excellent Good Fair Poor

Are you currently experiencing any physical problems? (e.g. headaches, body aches, stomach problems) Yes No

If yes, please explain _____

Date of last physical examination: ___/___/___ If you are taking any medications – please list them below:

Medication(s) – Prescription or Over the Counter	Dosage	How Long

Family Physician's Name _____ Phone _____

Previous hospitalizations for medical reasons: Date _____ Reason _____
Date _____ Reason _____

Previous hospitalizations for mental health treatment: _____ Approx dates _____ Duration _____

If yes, please explain including name of hospital, doctor and phone number
Hospital _____ Doctor _____ Phone number _____

Have you ever had any previous counseling experience? _____ Approx dates _____ Duration _____

Counselors' names & addresses: _____

Reason(s) _____

What were the results of your previous counseling experience(s)? _____

Have you ever had any serious thoughts about suicide? _____ Have you ever attempted suicide? _____

What concerns have led you to pursue counseling? _____

Where are your concerns causing the most problems for you? Check all that apply:

Home Work Marriage Other Relationships God

When did the problem(s) begin and how long has it been going on? _____

Have any concerns about you been identified by others? _____

Please indicate which of the following areas are currently problems for you. Check all that apply:

<input type="checkbox"/> Excessive anxiety or worry	<input type="checkbox"/> Loss of appetite/increased appetite
<input type="checkbox"/> Feeling lonely	<input type="checkbox"/> Lacking self-confidence
<input type="checkbox"/> Angry feelings	<input type="checkbox"/> Issues with food and/or weight
<input type="checkbox"/> Concerns about finances	<input type="checkbox"/> Abuse of alcohol and/or non-prescription drugs
<input type="checkbox"/> Feeling “numb” or cut off from emotions	<input type="checkbox"/> Delusions
<input type="checkbox"/> Angry outbursts	<input type="checkbox"/> Feeling distant from God
<input type="checkbox"/> Excessive fear of specific places/objects	<input type="checkbox"/> Hallucinations
<input type="checkbox"/> Difficulty making friends	<input type="checkbox"/> Inability to concentrate while at school/work
<input type="checkbox"/> Feeling as if you’d be better off dead	<input type="checkbox"/> Crying spells
<input type="checkbox"/> Feeling manipulated or controlled by others	<input type="checkbox"/> Nightmares
<input type="checkbox"/> Difficulty making decisions	<input type="checkbox"/> Loss of interest in usual activities/lack of motivation
<input type="checkbox"/> Loss of interest in sexual relationships	<input type="checkbox"/> Obsessions or compulsions with specific activities
<input type="checkbox"/> Feeling sexually attracted to those of your own sex	<input type="checkbox"/> Inability to control thoughts
<input type="checkbox"/> Concerns about physical health	<input type="checkbox"/> Feeling trapped in rooms/buildings
<input type="checkbox"/> Blackouts or temporary loss of memory	<input type="checkbox"/> Hearing voices
<input type="checkbox"/> Insomnia (no sleep) or Hypersomnia (sleep all the time)	<input type="checkbox"/> Feeling that people are “out to get you” or that you’re being watched

What would you like to accomplish or gain from your sessions with the Counseling Ministry? _____

What action have you taken to deal with the above situation? ie: small groups, support groups, etc. _____

Describe any strengths or weaknesses that you have that would either help or hinder the problem(s) _____

Do you have any resources that might be helpful in this situation? ie: friends, relatives, etc. _____

What additional information would you like to share? _____

For Counseling Center Office Use Only:

Assigned to:

Stephen Ministry _____

Lay Counseling _____

Staff Counseling _____

Referred to: _____
