COUNSELING INTAKE FORM

Date: ____________

Name(Patient/Client) ________________________________ Date of Birth: _______ Social Security _______________

Marital Status: Single ___ Engaged ___ Married ___ Divorced ___ Widowed ___ Separated ___ Date: ____________

Race: ____________________ Ethnicity: ______________________ Nationality: _____________________

Country(Nation) of Citizenship:____

Parent / Guardian's Name (*minor clients*) ____________________________ Partner's Name: _______________________

Additional Family Members & Ages: ____

____

Home Address: ____ City _________________________ Zip __________

Home Phone ______________________ Work Phone ______________________ Cell Phone ____________________

Fax Number _____________________ Leave Message at Home? Yes __ No __ Leave Message at Work? Yes __ No __

In Case of Emergency Contact Name/Phone Number:____

E-mail Address _________________________________ Web-page or My Space _________________________________

Employer's Name _______________________________ Address ____

Job Title ______________________________________ Length of time employed by this employer ________________

Referred by: ____________________________________ Phone: _______________________________

Religious Background: ____

Church: ____ Address: ____

Pastor: ____ Phone: _______________________________

Physician: _____________________________________ Phone: _______________________________

Psychiatrist: ___________________________________ Phone: _______________________________

Attorney: ______________________________________ Phone: _______________________________

Probation Officer: _______________________________ Phone: _______________________________

Highest Level of Education: __________ Major ____

Schools graduated from ____

Insurance Company: _____________________________________ Policy Number: ______________________________

Have you ever filed for bankruptcy? Yes ___ No___ Have you ever been involved in a lawsuit? Yes ___ No___

Have you ever been incarcerated? Yes ___ No___ Have you ever had an abortion Yes ___ No___

Have you ever been in a relationship with someone who has had an abortion? Yes ___ No___

What was your relationship with them?____

Current Weight: ______ Height: ________ Eyes: ________ Hair: ________ Handedness: Right___ Left___

Tattoos, body modifications, piercings:____

Disabilities: Type:__________________________________ Degree of:________________________________

Type:__________________________________ Degree of:________________________________

Previous Therapy? Yes ___ No ___ Former Therapist: ____

Describe the benefit of your previous therapy ____

____

Military History including MOS: ____

Type of Military Discharge:____

CONSENT TO COUNSELING

I, the undersigned, am requesting counseling and / or consultation services by *(Check the box next to the provider you will be seeing)*

- ☐ **Harry L. Morgan, PhD, LMHC**
- ☐ **Alfred James, MA, LMHC**
- ☐ **Chima Lubin, MA, LMFT**
- ☐ **Jeff Duncan, MPA, MAC, RMHCI**
- ☐ **Donna Mays, MA, RLMHCI**

This authorizes your counselor to provide consultation and referral services. I have been informed of the nature and purposes of this service, and that my consent can be revoked in writing prior to, and / or during the consultation period.

I have read and fully understand the above authorization for counseling / consultation. No guarantee or assurance has been made to me as to any of the results that may be obtained from these services. This is a release of any and all liability to my counselor and/or the office staff from any decisions or actions that I may or may not take as a result of the counseling I receive at Biblical Counseling Center.

I give consent to release the information provided during my therapeutic evaluation and counseling sessions for the duration of my counseling to be shared with Dr. Ronald Aung-Din, neuro-psychiatrist who is an associate of our center and the counseling staff of the Biblical Counseling Center, when appropriate.

Furthermore, I have received a copy of the Licensed Mental Health Counselor Client Services Agreement in compliance with HIPAA.

Client's Signature: ______________________________________

Signature of Parent or Guardian if client is under 18 ______________________________

Staff Signature: ______________________________________

MEDICAL HISTORY   Please check (✔) physical, neurological and behavioral conditions you have.

General Physical	Neurological	Behavioral
__ Abortion *(my own or my partner)*	__ Amnesia	__ Alcohol Consumption (*description* ______________) (*amount per week* ___________)
__ Allergies	__ Autism	__ Weight Gain / Loss (circle which) (*description* ______________)
__ Bowel/Bladder	__ Blackouts	__ ADD / ADHD
__ Cancer	__ Brain Injury	__ Alcohol Consumption
__ Diabetes	__ Brain Surgery	__ Appetite Changes
__ Heart Problems	__ Brain Tumor	__ Bulimia / Anorexia (circle which)
__ High Blood Pressure	__ Concussion	__ Change in Sexual Drive
__ Hypoglycemia	__ Dizziness	__ Compulsive Sexual Activity
__ Liver Problems	__ Electro-Shock Therapy	__ Constant Hunger
__ Lung Problems	__ Episodic Disorientation	__ Déjà vu
__ Menstrual Irregularities	__ Hallucinations	__ Fatigue
__ Multiple Sclerosis	__ Headaches	__ Food Cravings
__ Nausea/Vomiting	__ Headaches / Migraines	__ Heat/cold sensitivity
__ Problems Walking	__ Loss of Consciousness	__ Impotence
__ Rashes	__ Memory Problems	__ Insomnia
__ Thyroid Dysfunction	__ Neuropathic Pain	__ OCD
__ Tremors	__ Parkinson's Disease	__ Personality Change
__ Unusual Hair Loss	__ Seizures (including epilepsy)	__ Physical Change
__ Urinary / Kidney Problems	__ Sensory Distortion	__ Speech Problems
__ Visual Problems	__ Stroke	__ Tobacco Usage (*amount per week* _________)
__ Weakness	__ Tourette's Syndrome	

List all prescription and over-the-counter medications:

Prescription Medication	Dosage	Prescription Medication	Dosage
____________________	_______	____________________	_______
____________________	_______	____________________	_______
____________________	_______	____________________	_______
____________________	_______	____________________	_______
____________________	_______	____________________	_______

List all non-prescription, over-the-counter medications and vitamin/mineral therapies:

Non-Prescription Medication	Dosage	Non-Prescription Medication	Dosage
____________________	_______	____________________	_______
____________________	_______	____________________	_______
____________________	_______	____________________	_______

PERSONAL HISTORY / PROBLEM EVALUATION
BASIC PROBLEM IDENTIFICATION

Please check any of the follow symptoms or conditions you have had or are now experiencing.

CONDITION:	PAST More than 6 months	PRESENT Less than 6 months
Mood high & lows	____	____
Irritability	____	____
Excessive stress	____	____
Crying spells	____	____
Phobias or fears	____	____
Confusion	____	____
Low self-esteem	____	____
Compulsive behaviors	____	____
Depression	____	____
Extreme nervousness	____	____
Lack of Motivation	____	____
Indecisiveness	____	____
Loss of memory	____	____
Fantasizing	____	____
Use of pornography	____	____
Physical abuse of children	____	____
Sexual abuse of children	____	____
Physical abuse of others	____	____
Excessive sexual activity	____	____

CONDITION:	PAST More than 6 months	PRESENT Less than 6 months
Physical abuse from others	____	____
Sexual abuse from others	____	____
Excessive worries	____	____
Difficulty concentrating	____	____
Hearing unseen voices	____	____
Frequent loss of temper	____	____
Acting out violence	____	____
Frequent residence changes	____	____
Frequent employment change	____	____
Bed wetting past age 6	____	____
Fire setting past age 6	____	____
Blaming others frequently	____	____
Lack of sexual desire	____	____
Compulsive Sexual Activity	____	____
Spiritual confusion	____	____
Thoughts of suicide	____	____
Difficulty reading	____	____
Inability to comprehend math	____	____
Inability to express yourself	____	____
Involvement with the occult	____	____

1. When (approximately) did you have a complete physical examination? _______ Where? _________________
2. What physical disorders do you have, if any?

___

___

___

3. Describe your current relationship to God.

___

___

___

BACKGROUND INFORMATION

(*Briefly Answer the Following*)

1. Identify and describe the problem as best as you can.

2. What have you done to resolve the problem?

3. What are you seeking from this counseling?

4. What immediate circumstances have led to your making this appointment?

5. What additional information do you think would be helpful to the counselor?