CALVARY LIFE Counseling Center

INTAKE FORM

Today's Date: _____

Confidential History (If more space is needed, please use back of page.)

Referred By: _____

Name: _____ Date of Birth: _____

Present Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (___) _____-_____ Message OK? ❑ Yes ❑ No E-mail: _____

Cell Phone: (___) _____-_____ Message OK? ❑ Yes ❑ No Occupation: _____

Education Level: _____ Sex: ❑ M ❑ F

Church you attend: _____ Religion: _____

In case of an emergency contact: _____ Phone: _____

Marital Status: (Check all that apply.)

❑ Married, if so how long?_____ Are there current marital problems? ❑ Yes ❑ No Comments: _____

❑ Living together, if so how long? _____

❑ Widowed, if so how long were you married? _____ How long ago did your spouse pass away?_____

❑ Separated, if so how long have you been separated? _____

❑ Divorced, if so how long were you married?_____ How long ago did you divorce?_____

❑ Never Married

Current Spouse's Name: _____

Spouse's Occupation: _____

Children:

Name: _____ Sex: ❑ M ❑ F Age:_____ Living with you? _____

Name: _____ Sex: ❑ M ❑ F Age:_____ Living with you? _____

Name: _____ Sex: ❑ M ❑ F Age:_____ Living with you? _____

With whom were you raised? _____

Marital Status of Parents: (Check all that apply.)

❑ Married (Years Married):_____

❑ Separated (Years Married): _____

❑ Never Married ❑ Living Together ❑ Divorced

Siblings:

Name: _____ Sex: ❑ M ❑ F Age: _____

Name: _____ Sex: ❑ M ❑ F Age: _____

Name: _____ Sex: ❑ M ❑ F Age: _____

What are your main concerns/reasons for seeking counseling at this time? Was there a special event?

_____

_____

_____

When did these symptoms begin? _____

How serious does this problem feel to you? 1 2 3 4 5

Mildly Upsetting ⟷ Extremely Serious

Please circle the items that cause you the most trouble in your life:

Abuse	Extravagance	Indecisiveness	Mood swings	Stinginess
Addictions	Family members	Indifference	Obsessive thoughts	Stress
Anger	Fantasizing	Inferiority	Panic	Tardiness
Anxiety	Fear	Insecurity	Poor concentration	Thought process
Apathy	Friends	Insignificance	Poor decisions	Unapproachability
Callousness	Giving up	Irresponsibility	Prejudice	Underachievement
Carelessness	Gossip	Jealousy	Pride	Unfaithfulness
Compulsiveness	Greed	Lack of awareness	Procrastination	Ungratefulness
Covetousness	Guilt	Lack of fairness	Rebellion	Unreasonableness
Cowardice	Harshness	Lack of goals	Rejection	Unresponsiveness
Daydreaming	Headaches	Lack of perceptiveness	Resistance	Wastefulness
Deception	Health	Lack of wisdom	Restlessness	Withdrawal
Denial	Hypocrisy	Laziness	Rudeness	Worry
Disorganization	Immorality	Loneliness	Sadness	
Disrespect	Impulsiveness	Lustful thoughts	Self-gratification	
Dominance	Inadequacy	Lying	Selfishness	
Doubts	Incompleteness	Manipulation	Sex	
Envy	Inconsistency	Memory	Spouse	

Psychological History:

Is there a family history of treatment for psychological/psychiatric conditions? ❑ Yes ❑ No

Comments: _____

Have you had previous counseling? ❑ Yes ❑ No

With whom and when: _____

What did you learn? _____

Have you ever felt suicidal? ❑ Yes ❑No Do you feel that way now? ❑ Yes ❑ No

Comments: _____

Do you drink alcohol? ❑ Yes ❑ No What type: _____ Frequency: _____

Do you use tobacco? ❑ Yes ❑ No What type: _____ Frequency: _____

Do you use other drugs? ❑ Yes ❑ No What type: _____ Frequency: _____

Have you been a victim of physical or sexual abuse/assault or incest? ❑ Yes ❑ No Comments: _____

_____

Do you have addictions? If so, please mark all that apply: ❑ Drugs ❑ Alcohol ❑ Pornography ❑ Food

❑ Gambling ❑ Other _____

Please check all that apply:

Abortion	❑ Yourself ❑ Family Member	Head Injury	❑ Yourself ❑ Family Member
ADD or ADHD	❑ Yourself ❑ Family Member	Homosexuality	❑ Yourself ❑ Family Member
Addictions	❑ Yourself ❑ Family Member	Incest	❑ Yourself ❑ Family Member
Alcoholism	❑ Yourself ❑ Family Member	Manic/Depression	❑ Yourself ❑ Family Member
Anxiety	❑ Yourself ❑ Family Member	Memory problems	❑ Yourself ❑ Family Member
Appetite disturbance	❑ Yourself ❑ Family Member	Mood swings	❑ Yourself ❑ Family Member
Child Abuse	❑ Yourself ❑ Family Member	Psychiatric hospitalization	❑ Yourself ❑ Family Member
Depression	❑ Yourself ❑ Family Member	Schizophrenia	❑ Yourself ❑ Family Member
Delusions	❑ Yourself ❑ Family Member	Self-harm	❑ Yourself ❑ Family Member
Drug abuse	❑ Yourself ❑ Family Member	Sleep disturbance	❑ Yourself ❑ Family Member
Eating problems	❑ Yourself ❑ Family Member	Suicidal behavior/thoughts	❑ Yourself ❑ Family Member
Grief issues	❑ Yourself ❑ Family Member		
Hallucinations	❑ Yourself ❑ Family Member		

Spiritual History:

Describe your relationship with God. _____

_____

How do you know that you are saved? _____

_____

How would you explain to another person how to become a Christian?_____

_____

What religions have you explored? _____

Have you ever experimented with the occult, witchcraft , psychic readings, or ouji board?_____

_____

Health History

Please list any major medical conditions:

_____

_____

Current Physician: _____ Phone #: (____) _____- _____

Date of Most Recent Visit:_____ Reason: _____

Medications You Take: ❑ I do not take prescription medication at this time.

Medication: _____ For What Condition: _____

Medication: _____ For What Condition: _____

Medication: _____ For What Condition: _____

Medication: _____ For What Condition: _____

Is there any other significant information the form did not ask that you would like to add?_____

_____

_____

COUNSELING PROGRAM:
The Counseling Program at Calvary Church is a biblically based ministry offered by lay counselors at no cost. Appropriate candidates are offered 10 sessions with a lay counselor. If we cannot meet your needs, referrals are available. All lay counselors are required to be in group supervision directed by the Pastor of Lay Counseling, Jim McCarty, and will also be reviewed by Robyn Bettenhausen Geis, PsyD.

WAIVER OF LIABILITY:
Having sought lay counseling through Calvary Church, a non-profit Christian organization, you hereby acknowledge your understanding of the following:

1. All counseling will be provided by lay counselor volunteers. Lay counselors shall be under the supervision of a licensed professional as well as the Pastor of Lay Counseling.
2. All counseling services provided in the counseling program are provided in accordance with biblical principles as determined by Calvary Church.
3. Your confidentiality shall be protected with the following exceptions. In certain situations the counselor is mandated by law to take actions to protect the client or others from harm, and he/she may be required to reveal limited pertinent information. Those situations include: child abuse, viewing child pornography, danger to self, threat of violence to others, adult violence witnessed by a minor, and elder/dependent adult abuse.
4. Email and all telephone communication, including texting, is for the express purpose of scheduling appointments **Only.** Calvary Church cannot guarantee confidentiality via electronic communication of any kind.
5. At times , if it is in the counselee's best interest, Calvary Church Lay Counseling will refer the counselee to an appropriate care giver.
6. Your information will be discussed confidentially and anonymously by the Lay Counseling Ministry only during counselor supervision.
7. Please notify your counselor 24 hours in advance if you cannot make your appointment. Failure to do so may result in the termination of counseling.
8. Please contact Jim McCarty, the lay counseling pastor, at 714-550-2352, if your Calvary Church counseling experience is unsatisfactory in any way. However, Calvary Church, the lay counselors, and supervisors are all released from any liability as pertains to that experience.

By signing below I affirm that I have read and agree to the above conditions.

_____ _____
Counselee Date

_____ _____
Counselee Date

INTAKE SUMMARY

OFFICE USE ONLY

Please fill in the best appointment time & day to meet with a counselor
Best Day of the week/Home_____
Best Time of day _____AM_____PM

Name of Client:_____ Intake Interview Date:_____

SIGNIFICANT ISSUES AND THEMES
POSSIBLE APPROACHES
GOD VIEW

_____

Intake Counselor Signature