CALVARY LIFE Counseling Center

INTAKE FORM FOR COUPLES

Today's Date: _____

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

Referred by: _____

Husband Name: _____ Date of Birth: _____

Wife Name: _____ Date of Birth: _____

Present Address:_____

City: _____ State: _____ Zip: _____

E-Mail: _____

Home Phone: _____ His Cell Phone: _____

Her Cell Phone: _____

Church you attend: _____

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?_____
- ❑ Separated, if so how long have you been separated?_____
- ❑ Divorced, if so how long were you married?_____ How long ago did you divorce?_____

Children:

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

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

Name: _____ Sex: ❑ M ❑ F Age:_____ Living with yo

Please fill in the best appointment tine and day to meet with a counselor.

Best day of the week: _____

Best time of day: _____AM _____PM

With whom were you raised? _____

Marital Status of Parents: (Check all that apply.) ❑ Married (Years Married):_____ ❑ Never Married
❑ Separated (Years Married): _____ ❑ Living Together ❑ Divorced

Siblings:

Name:_____ Sex: ❑ M ❑ F Age: _____
Name:_____ Sex: ❑ M ❑ F Age: _____
Name:_____ Sex: ❑ M ❑ F Age: _____

Employer: _____ Work Phone: (____) _____-_____
Occupation:_____ Other Phone: (____) _____-_____
Satisfied with your occupation? ❑ Yes ❑ No Education Level: _____

What are your main concerns/reasons for seeking counseling? _____

_____

_____

When did these symptoms begin? _____

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

Mildly Upsetting ⟷ Extremely Serious

Did a specific event lead to this session? ❑ Yes ❑ No Comments: _____

_____

_____

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

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

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: _____

_____

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 ❑ Gambling

❑ Other _____

Please list all family members, including yourself, who suffer from the following problems:

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	Seizures	❑ Yourself ❑ Family Member
Drug abuse	❑ Yourself ❑ Family Member	Sleep disturbance	❑ Yourself ❑ Family Member
Eating problems	❑ Yourself ❑ Family Member	Speech problems	❑ Yourself ❑ Family Member
Grief issues	❑ Yourself ❑ Family Member	Suicidal behavior	❑ Yourself ❑ Family Member
Hallucinations	❑ Yourself ❑ Family Member	Suicidal thoughts	❑ 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 been involved in the occult such as witchcraft or psychic readings?_____

Health History:

Please list any major medical conditions in your family: _____

_____

_____

Any additional medical conditions or health issues: _____

_____

_____

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

Date of Most Recent Visit:_____ Reason: _____

When was your last physical? _____

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

Medication: _____ For What Condition: _____

Medication: _____ For What Condition: _____

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

_____

_____

With whom were you raised? _____

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

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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 (Husband) Date

_____ _____

Counselee (Wife) Date

CALVARY
LIFE
Counseling Center

INTAKE SUMMARY

OFFICE USE ONLY

Please fill in the best appointment tine and day to meet with a counselor
Best day of the week: _____
Best time of day: _____AM _____PM

Name of Clients: _____Intake Interview Date:_____

SIGNIFICANT ISSUES AND THEMES
POSSIBLE APPROACHES
GOD VIEW

_____
Counselor Signature