



SHEEP GATE CHRISTIAN COUNSELING

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CONFIDENTIAL INTAKE ASSESSMENT

The purpose of this assessment is to obtain a comprehensive understanding of your life experience and background. Completing these questions as fully and as accurately as you can, will benefit you through the development of a treatment program suited to your specific needs. Please return this assessment at your first scheduled appointment.

PLEASE COMPLETELY FILL OUT THE FOLLOWING PAGES

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone number(s) you want to be contacted at:

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security #: _____ Gender: _____ Age: _____ DOB: _____

Place of Birth: _____ **EDUCATION:** Highest level achieved: _____

College Major or emphasis: _____

Additional Special Training: _____

Who referred you? _____

Who should we contact in an emergency? Name: _____

Relationship: _____ Address: _____

Telephone: _____

SOCIO-ECONOMIC HISTORY (check all that apply for patient)

Living situation:

- housing adequate
- homeless
- housing overcrowded
- dependent on others for housing
- housing dangerous/deteriorating
- living companions dysfunctional

Social support system:

- supportive network
- few friends
- substance-use-based friends
- no friends
- distant from family of origin

Sexual history:

- heterosexual orientation
 - homosexual orientation
 - bisexual orientation
 - currently sexually active
 - currently sexually satisfied
 - currently sexually dissatisfied
 - age first sex experience _____
 - age first pregnancy/fatherhood ____
 - history of promiscuity age ____ to ____
 - history of unsafe sex age ____ to ____
- Additional information: _____

Employment:

- employed and satisfied
- employed but dissatisfied
- unemployed
- coworker conflicts
- supervisor conflicts
- unstable work history
- disabled: _____

Military History:

- never in military
- served in military - no incident
- served in military - **with** incident

Cultural History:

- cultural identity (e.g., ethnicity): _____
- describe any cultural issues that contribute to current problem: _____

Leisure History:

- currently active in community/recreational activities? Yes No
- formerly active in community/recreational activities? Yes No
- how is most of your free time occupied? _____

Financial situation:

- no current financial problems
- large indebtedness
- poverty or below-poverty income
- impulsive spending
- relationship conflicts over finances

Legal history:

- no legal problems
- now on parole/probation
- arrest(s) not substance-related
- arrest(s) substance-related
- court ordered this treatment

jail/prison _____ # of times)
 total time served: _____
 describe last legal difficulty: _____

Significant relationship status (check one):

- single (never married)
- divorced
- engaged
- remarried
- married
- committed relationship
- separated
- widowed

If engaged, married, separated, divorced or widowed, for how long? _____

Living in a committed relationship? Yes No How long have you been together? _____

Number of previous marriages for you: _____ For your spouse: _____

If married, spouse's name: _____ Age: _____ Occupation: _____

Is your spouse supportive of seeking counseling? Yes No Unsure Spouse doesn't know

Please provide a brief description of your spouse (e.g., angry and controlling; outgoing and supportive): _____

What is your spouse or partner's religious affiliation? _____

CHILDREN: None: _____

Please list your children (including step, adopted, foster) below:

Name	Gender	Age/Yr. of Death	Relationship w/you	Living with whom?

Who else lives with you? _____

SPIRITUAL/RELIGIOUS HISTORY

Check the appropriate box if you want Christian Counseling Yes No

Do you regularly attend a church, synagogue, or other religious institution? Yes No

If yes, which one? _____

Describe your participation: _____

Childhood religious affiliation, if different from above: _____

Describe the religious atmosphere you were raised in? _____

How did you feel about your childhood religion? _____

What did your religious training teach you about life? _____

What is the role of religion/spirituality in your life? _____

Describe any spiritual experiences that have shaped your life: _____

What is your sense of your purpose in life? _____

CHIEF COMPLAINT (Check All That Apply To You):

- | | | |
|--|--|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Feeling that you are not real | <input type="checkbox"/> Fear of going crazy |
| <input type="checkbox"/> Low Energy/Fatigue | <input type="checkbox"/> Feeling that things around you are not real | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Low Self-esteem | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Racing Thoughts |
| <input type="checkbox"/> Poor Concentration | <input type="checkbox"/> Unpleasant thoughts won't go away | <input type="checkbox"/> Anorexia/Bulimia |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Anger/Frustration | <input type="checkbox"/> Excessive Behaviors (spending, gambling) |
| <input type="checkbox"/> Worthlessness | <input type="checkbox"/> Easily Agitated/Annoyed | <input type="checkbox"/> Obsessions/Compulsions |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Impulsive Behavior | <input type="checkbox"/> Can't hold onto an idea |
| <input type="checkbox"/> Trouble Sleeping/Sleep Too Much | <input type="checkbox"/> Argues/Blames Others | <input type="checkbox"/> Delusions |
| <input type="checkbox"/> Loss of Appetite/Overeating | <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> See things others don't |
| <input type="checkbox"/> Grief/Loss | <input type="checkbox"/> Prescription Abuse | <input type="checkbox"/> Hearing Voices |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Laxative/Diuretic Abuse | <input type="checkbox"/> Not thinking clearly/confusion |
| <input type="checkbox"/> Isolation/Social Withdrawal | <input type="checkbox"/> Emotional Abuse Issues | <input type="checkbox"/> Sexual Problems |
| <input type="checkbox"/> Apathy | <input type="checkbox"/> Physical Abuse Issues | <input type="checkbox"/> Marital Problems |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Sexual Abuse Issues | <input type="checkbox"/> Other Relationship Problems |
| <input type="checkbox"/> Anxiety/Panic | <input type="checkbox"/> Spousal Abuse Issues | <input type="checkbox"/> Career/Work problems |

PRESENTING PROBLEM/CHIEF COMPLAINT DESCRIPTION

State in your own words the nature of your main problem(s) and a brief history of your complaint(s) from onset to present:

On the scale below please use an "X" to indicate the severity of your problem(s):



A. Were you ever hospitalized because of mental illness? Yes No

B. How many times have you been hospitalized? _____

C. When were you first diagnosed with a mental illness? _____

D. Have you previously consulted anyone about your present problem(s)? Yes No

COUNSELING HISTORY

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, residential/in-patient care or hospitalizations, please list the names of the therapists, hospitals or programs below:

Therapist's Name/Hospital or Program	Major Issue/Diagnosis	Dates

- 2. Have you ever attempted suicide or homicide? Yes No
 - a. If yes, how many times _____
- 3. Are you currently feeling suicidal or homicidal? Yes No
 - a. If yes, do you have a plan? Yes No
 - b. If you have a plan, please describe: _____
 - c. Do you have the means to carry out your plan? Yes No
 - d. If yes, please explain: _____

MEDICATION COMPLIANCE

A. If you are presently taking psychotropic medication(s) please list each one below:

Name	Dosage	Frequency

- B. Do you know your medication schedule? Yes No
- C. Do you think the medication is helping? Yes No
- D. Do you experience any side-effects? Yes No

If yes, describe symptoms: _____

MEDICAL HISTORY: Please check below which of the following medical symptoms you have experienced in the **Past (P)** and/or **Currently (C)**:

P	C	P	C	P	C	P	C	P	C	P	C

Please list any other major conditions, illnesses, accidents, surgeries, treatments or hospitalizations you have had and when they occurred? _____

Are you currently receiving any medical treatment?

Yes No

If yes, please describe: _____

Please list any non-psychotropic prescription and over-the-counter medications you are currently taking and the reasons for taking them. (List even if you seldom use, or take only as needed.)

Name of Medication(s)	Dose/Schedule	Reason for Taking

Are you taking these medications according to the doctor's recommendations?

Yes No

If no, please explain: _____

Date and outcome of last physical exam: _____

What is your height? _____ What is your weight? _____ Describe any regular exercise regimen: _____

FAMILY HISTORY

Please list your father, mother, sisters, brothers, step family relations, or family members who had significant effect on your life (either positive or negative).

Name	Gender	Age/Yr. of Death	Relationship w/you	Describe your relationship with each family member listed (e.g., loving & supportive, argumentative & controlling, etc.)

DESCRIBE YOUR CHILDHOOD FAMILY EXPERIENCE:

- Outstanding home environment
- Normal home environment
- Chaotic home environment
- Witnessed physical/verbal/sexual abuse toward others
- Experienced physical/verbal/sexual abuse from others

1. Were there any special circumstances in your childhood? _____

2. Has anyone in your family ever been treated or hospitalized for substance abuse, mental health issues, or psychiatric conditions? Yes No

a. If yes, please describe: _____

3. Have any of your family members or friends ever attempted or committed suicide? Yes No

a. If yes, please describe: _____

SUBSTANCE ABUSE HISTORY

Family alcohol/drug abuse history:

- father stepparent/live-in
 mother uncle(s)/aunt(s)
 grandparent(s) spouse/significant other
 sibling(s) children
 other _____

Substance use status:

- no history of abuse
 active abuse
 no active abuse/dependence in 1-11 months
 partial abuse/dependence in 1-11 months
 no active abuse/dependence in over 12 months
 partial abuse/dependence in over 12 months

Substances used:

(complete all that apply)

- alcohol
 amphetamines/speed
 barbiturates/owners
 caffeine
 cocaine
 crack cocaine
 hallucinogens (e.g., LSD)
 inhalants (e.g., glue, gas)
 marijuana or hashish
 nicotine/cigarettes
 PCP
 prescription _____
 other _____

Current Use

First use age Last useage (Yes/No) Frequency Amount

First use age	Last useage	(Yes/No)	Frequency	Amount
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Treatment history:

- outpatient (age[s] _____)
 inpatient (age[s] _____)
 12-step program (age[s] _____)
 stopped on own (age[s] _____)
 other (age[s] _____)

Consequences of substance abuse (check all that apply):

- hangovers withdrawal symptoms sleep disturbance binges
 seizures medical conditions assaults job loss
 blackouts tolerance changes suicidal impulse arrests
 overdose loss of control amount used relationship conflicts
 other _____

Describe: _____

OCCUPATIONAL DATA

- A. What is your current occupation? _____
 B. Why did you choose your present occupation? _____
 C. How do you feel about your work situation? _____
 D. Are you considering changing employment? Yes No. Why? _____
 E. What are your long-term career goals? _____

TREATMENT EXPECTATION & GOALS

1. What is there about your present behavior that you would like to change? _____

 2. How would your life be different if you did not have the difficulties described previously? _____

 3. In a few words, what do you think therapy is all about? _____

 4. What do you hope to accomplish from therapy, and how long do you expect therapy to last? _____

 5. Please add any information not brought up by this questionnaire that may aid your therapist in understanding and helping you (List any additional problems or difficulty here): _____

Client's Signature: _____

Date: _____