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 are 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)
☐ engaged
☐ married
☐ separated
☐ divorced
☐ remarried
☐ committed relationship
☐ 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, and 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):

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

PRESENTING PROBLEM/CHIEF COMPLAINT DESCRIPTION

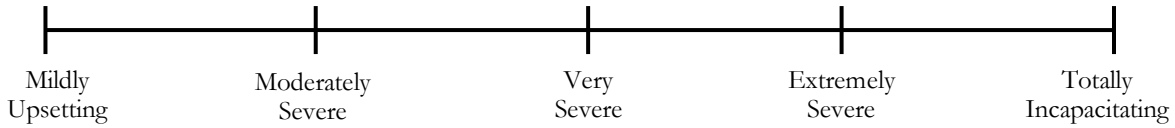
State in your own words the nature of your main problem(s) and a brief history of your complaint(s) from onset to present:

_____

_____

_____

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 it: _____
   _____
   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	
		Fainting			Constipation			Premenstrual Syndrome			Back Pain			Stroke
		Asthma			Stomach Ailments			Weight Problems			Chest Pain			Heart Disease
		Vomiting			Ulcer			Allergies			Painful Joints			Tuberculosis
		Dizziness			Unusual Bleeding			Diabetes			Head Injury			Birth Defects
		Headaches			Skin Problems			Cancer			Pounding Heart			Trouble Breathing
		Neck Pain			HIV Positive			High Blood Pressure			Jaw/Dental Pain			Chills/Hot Flashes
		Chronic Pain			Hepatitis A/B/C			Thyroid Problems			Unconsciousness			Tingling/Numbness

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 a 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 over12 months
[ ] partial abuse/dependence in over12 months

Substances used:

(complete all that apply)	First use age	Last usage	Current Use (Yes/No)	Frequency	Amount
[ ] 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_____					

Treatment history:

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

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 _____

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 EXPECTATIONS & 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 difficulties here): _____

_____

Client's Signature: _____ Date: _____