NEW BEGINNINGS COUNSELING CENTER

Intake Form

The following form, which will become a part of your confidential record, will enable us to gain a quicker understanding of you. Please answer each question as completely and as carefully as you can. Please use the bottom of the last page for any additional information or comments.

Name_____ **Date of Birth**_____ **Age**____ **Sex**_____

Present Address_____**Phone**_____
Number Street

_____**Cell Phone**_____
City State Zip Code

_____
Email address

Marital Status: Single_____ **Married**_____ **(# of Years**_____**) Divorced**_____ **Separated** _____ **Widowed**_____

Presently Living With: Parents____ **Spouse**____ **Roommate**____ **Alone**____ **Other**_____

Family Member to notify in case of Emergency:

Name_____**Address**_____

Phones_____**Relationship**_____

Occupation: _____**Total Hours worked per week**_____

Employed by:_____ **Years of Education:** _____**Phone**_____

Referred by: _____

Religious Affiliation_____ **Pastors Name** _____

Active Member_____ **Inactive Member**_____ **Church You Attend** _____

Members of Current Household: (living with you in the same house)

Relationship	Name	Age	Last Grade Completed	Occupation

Describe any physical problems you have that require medication or physical care:_____

_____

Are you currently receiving medical treatment? _____ **If so, Doctors name:** _____

Health Info: _____

Are you currently taking medications?_____ **Please list Medications**_____

_____

Previous Counseling/Therapy? _____**If yes, when?**_____

Where & with whom?_____
Name **Title**

_____
Address **Phone**

Please list your parents (living or deceased) and any brothers or sisters:

Relationship	Name	Age	Last Grade in School	Occupation	How often do you see them?

In your own words, briefly describe the main problem which prompted you to seek counseling at this time.

_____

_____

Have there been times when the problem got better or disappeared? Yes _____**No**_____

If so, when?_____

Were there times when the problem was especially bad? Yes _____**No**_____ **Explain**_____

_____

Please list any persons you feel may have played a major role in causing your problems_____

_____

Please list any person who helps you cope with your problems_____

_____

Please check the type of counseling you desire:

Individual____ **Pre-marital** ____ **Marital**____ **Child/Teen**_____ **Short Term Crisis** _____ **Family**_____ **Addiction** ____

Group_____ **Divorce Recovery**_____ **Grief/Loss** _____ **Illness** _____ **Abuse**_____ **Domestic Violence**_____ **Not sure**___

Anger Management ____ **Stress Management** ____ **Sexual Issues** _____ **Emotional Healing** _____ **Relationships** _____

Other_____

Please make a check mark next to each item which identifies an area of concern for you. Place two checks by those items that are most important..

_____Addictions (alcohol, drugs, food, gambling, sex, etc.)

_____Anger

_____Depression

_____Education/Learning Difficulties

_____Eating Difficulties

_____Fearfulness/Anxiety/Panic Attacks

_____Marital Problems

_____Health/Physical Problems

_____Problems with social relationships

_____Financial Problems

_____Mental Health Problems

_____Problems with children

_____Problems with parents

_____Religious/Spiritual Concerns

_____Sexual Concerns

_____Thoughts of Suicide

_____Trouble making Decisions/confusion

_____Unhappy most of the time

_____Addiction of a family member

_____Work/Job related

_____Worry

_____Other (Specify)_____

I, _____(print your name), have read the policy sheet, completed the intake form, and have submitted to counsel of my own free will. I will not hold New Beginnings Counseling Center, nor its staff, responsible for the outcome of therapy. (It is my choice to follow the counsel or not)

_____ _____

Signature **Date**

For clients 17 years and under, the signature of his/her guardian or custodial parent is required.

_____ _____

Signature of Parent or Guardian **Date**

Questions, Comments or further information: