Compassion Centered Counseling

Intake Form

PLEASE PRINT CLEARLY Today's Date ______________________

PERSONAL INFORMATION

CLIENT NAME ________________________________

Date of Birth ____________________ Gender __________

Address ____

City, State_______________________ Zip ______________

Home Phone ____

Work Phone ____

Cell Phone ____

RESPONSIBLE PARTY _______________________________

Responsible Party's SSN _____________________________

Address (if different) ______________________________

City, State ________________________Zip ____________

Home Phone (if different) ___________________________

Work Phone (if different) ___________________________

Cell Phone (if different) ____________________________

Please indicate with an * which phone numbers we may NOT leave a message.

Client's relationship to Responsible Party (check one): Self_______ Spouse_______ Child_______ Other _______

Relative or friend in case of emergency ____
Name

____
Phone # Relationship

Select Current Relationship Status (check one)

Single (never married) ____ Married ____ Divorced ____ Separated ____ Widowed ____ Common Law ____
Partnered ____ Engaged ____

Date of Marriage ____________________ (or) Date of living arrangement ____________________

Name of a church attending ____

School (if a student) ____Years of Education __________

Employer ____Years with Employer__________

Source of referral ______________________________ Reason for referral ___________________________

How did you hear about Compassion Centered Counseling?

____

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FAMILY INFORMATION

NAME	M/F	AGE	DATE OF BIRTH	RELATIONSHIP TO CLIENT &/or MARITAL STATUS	EDUCATION	OCCUPATION
Client						
Spouse/Partner/Boyfriend/Girlfriend						
Children/Step Children						
1.						
2.						
3.						
4.						
5.						
6.						
Others Living in Household						
1.						
2.						
3.						
4.						
5.						
6.						

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MEDICAL INFORMATION

CLIENT NAME:

____

Have you ever been treated for emotional difficulties before (when and where?) ____________________________

____

Primary Care Physician: Name/Practice

____

Address____Phone ____________________

Date of last physical exam _____________________________ How is your general health now? ______________

Please list any prescription medications you currently use (Name, dosage, frequency):

____

____

____

____

Please list any over-the-counter medications and supplements you currently use: (Name, dosage, frequency):

____

____

Are you presently being treated by a physician for any physical condition? (Explain)

____

____

____

Have you had any serious illness? (List)

____

____

____

Describe any medical or psychiatric conditions of your parents or siblings:

____

____

How much exercise are you getting? ____

How many hours of sleep do you get on average? ____

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ADULT CHECKLIST of CONCERNS

PLEASE MARK ALL THAT APPLY:

___Abuse (Adult) physical, sexual, emotional
___Abuse (Childhood) physical, sexual, Emotional, neglect
___Alcohol Use
___Anger, irritability, hostility
___Anxiety, nervousness
___Attention, Concentration difficulty
___Behavior Problems
___Career concerns, goals, choices
___Changes in Appetite/Eating Habits
___Children, parenting, child management
___Codependence
___Criminal Activity
___Decision making, indecision
___Decreased Energy, fatigue
___Delusions
___Depressed Mood
___Disruption of Thought Process/Content
___Divorce, Separation
___Excessive Crying
___Family Conflicts

___Financial problems, debt, low income
___Gambling
___Grief, mourning, deaths
___Guilt
___Hallucinations
___Health illness, medical concerns
___Hopelessness
___Hyperactivity
___Impulsiveness
___Interpersonal Conflicts, relationships
___Irritability
___Loneliness
___Manic
___Marital conflict, infidelity, disconnection, remarriage
___Mood Swings
___Motivation low
___Obsessions, compulsions (repeated thoughts or Actions)

___Pain physical, headaches
___Panic or Anxiety attacks
___Paranoia
___Perfectionism
___Pessimism
___Physical Aggression
___Procrastination, work inhibitions
___Risky Behavior
___School/Work Problems
___Self Abusive Behavior
___Self-esteem, poor self-care
___Sleep Disturbance
___Stress, tension
___Suicidal Thoughts/Attempt
___Weight Gain
___Weight Loss
___Withdrawal, isolation
___Worthlessness
___Other (Specify below)

Other Concerns or how could your life be better?