MASTER PEACE CHRISTIAN COUNSELING

INTAKE SHEET

CLIENT INFORMATION

Primary Client _____
Last Name First Name MI Nickname

Address _____
Street City State Zip

Home Phone _____ Work _____ Cell _____

Email _____

Date of Birth _____ Age _____ Gender _____

Occupation _____

May we call you at your home? _____ Yes _____ No

May we call you at your office? _____ Yes _____ No

May we call you on your cell? _____ Yes _____ No

May we leave a message at your home? _____ Office? _____ Cell? _____

Current Marital Status:

Never Married___ Married___ Engaged___ Divorced___ Separated___ Widowed___

Name of Spouse (if applicable) or Parents (if client is a minor)_____

Date of Marriage _____ Spouse Date of Birth_____

Name of other family members:

_____ Age ____ Gender ____ Relationship _____

_____ Age ____ Gender ____ Relationship _____

_____ Age ____ Gender ____ Relationship _____

_____ Age ____ Gender ____ Relationship _____

_____ Age ____ Gender ____ Relationship _____

Your Education Level: GED____ High School Diploma____ College Degree___

Graduate Degree____ Degree In _____

Spouse's Education Level: GED___ High School Diploma___ College Degree___

Graduate Degree___ Degree In _____

Previous Marital History (if applicable):

SELF:

Name of Previous Spouse	Date of Marriage	Date of Divorce/Death
_____	_____	_____
_____	_____	_____
_____	_____	_____

SPOUSE:

Name of Previous Spouse	Date of Marriage	Date of Divorce/Death
_____	_____	_____
_____	_____	_____
_____	_____	_____

PERSONAL INFORMATION

Are you currently attending a church? Yes___ No___
If yes, what is the name of the church? _____
What is the denomination of the church? _____
Do you have a personal relationship with Christ? Yes___ No___ Unsure___
Are religious or spiritual issues important in your life? Yes___ No___
Are you aware of any religious or spiritual resources in your life that could be used to help you overcome your problems? Yes___ No___
If yes, what are they? _____
Would you like prayer as part of your counseling? Yes___ No___
Who referred you to our center? _____
May we contact them? Yes___ No___
How would you rate your health? _____
How many hours do you sleep each night? _____
How would you rate your diet? Very Healthy___ Healthy___ Average___ Poor___
Needs Improvement___
Do you have addictive/abusive issues with: Alcohol___ Illegal Drugs___ Prescriptions___
Sex___ Pornography___ Gambling___ Gaming___ Other: _____
Has your appetite or weight changed lately? _____
Are you currently on medication? Yes___ No___
If so, please complete the following:

Medication	Dosage	Physician	Purpose

PERSONAL CONCERNS

Briefly explain why you are coming to counseling and what you hope to gain from your experience. _____
_____
How much does this trouble you? Constantly___ Often___ Somewhat___ Not Very Much___
Comments concerning this problem: _____
_____
Have you been in counseling before? Yes___ No___
If so, for each incidence you remember, please complete the following:

1. Who was the counselor? _____
   What was the problem? _____
   How many sessions over what period of time? _____
   What were the results? _____
2. Who was the counselor? _____
   What was the problem? _____
   How many sessions over what period of time? _____
   What were the results? _____
3. Who was the counselor? _____
   What was the problem? _____
   How many sessions over what period of time? _____
   What were the results? _____

THOUGHTS AND BEHAVIORS

Please check how often the following thoughts occur to you:

1. Life is hopeless.	____ Never	____ Rarely	____ Sometimes	____ Frequently
2. I am lonely.	____ Never	____ Rarely	____ Sometimes	____ Frequently
3. No one cares about me.	____ Never	____ Rarely	____ Sometimes	____ Frequently
4. I am a failure.	____ Never	____ Rarely	____ Sometimes	____ Frequently
5. Most people don't like me.	____ Never	____ Rarely	____ Sometimes	____ Frequently
6. I want to die.	____ Never	____ Rarely	____ Sometimes	____ Frequently
7. I want to hurt someone.	____ Never	____ Rarely	____ Sometimes	____ Frequently
8. I am so stupid.	____ Never	____ Rarely	____ Sometimes	____ Frequently
9. I am going crazy.	____ Never	____ Rarely	____ Sometimes	____ Frequently
10. I can't concentrate.	____ Never	____ Rarely	____ Sometimes	____ Frequently
11. I am so depressed.	____ Never	____ Rarely	____ Sometimes	____ Frequently
12. God is disappointed in me.	____ Never	____ Rarely	____ Sometimes	____ Frequently
13. I can't be forgiven.	____ Never	____ Rarely	____ Sometimes	____ Frequently
14. Why am I so different?	____ Never	____ Rarely	____ Sometimes	____ Frequently
15. I can't do anything right.	____ Never	____ Rarely	____ Sometimes	____ Frequently
16. People hear my thoughts.	____ Never	____ Rarely	____ Sometimes	____ Frequently
17. I have no emotions.	____ Never	____ Rarely	____ Sometimes	____ Frequently
18. Someone is watching me.	____ Never	____ Rarely	____ Sometimes	____ Frequently
19. I hear voices in my head.	____ Never	____ Rarely	____ Sometimes	____ Frequently
20. I am out of control.	____ Never	____ Rarely	____ Sometimes	____ Frequently

Please rate the following symptoms on a scale of 0-2:

0 = Not significant/Non-existent 1 = Moderate/Sometimes 2 = Frequent/Severe

Excessive anger, easily frustrated	____	Hyperactivity	____
Mood swings (depression-manic)	____	Change or loss of friends	____
Excessive guilt or shame	____	Sexual problems	____
Loss of energy	____	Self-mutilation, cutting	____
Loss of interest in activities	____	Excessive stress	____
Suicidal thoughts	____	Anxiety or excessive fears	____
Suicide attempts (how many)	____	Learning disabilities	____
Lying	____	Work or school related problems	____
Manipulation	____	Hallucinations, delusions, thought distortions	____
Poor impulse control	____	Obsessive thoughts &/or compulsive behaviors	____

Please comment (e.g., examples, frequency, duration, effects on you) about each of the above thoughts/behaviors that occur frequently or are a concern to you. **Provide as much information as possible so the therapist can provide proper therapy. Use back of page if needed.**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

EMERGENCY CONTACT

Whom should we contact in case of emergency?

Name _____

Address _____

Home Phone _____ Cell Phone _____