

# COUNSELING INTAKE FORM

Date: \_\_\_\_\_

Client's Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security \_\_\_\_\_

Marital Status: Single \_\_\_ Engaged \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Separated \_\_\_ Date: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Nationality: \_\_\_\_\_

Parent / Guardian's Name (*minor clients*) \_\_\_\_\_ Partner's Name: \_\_\_\_\_

Additional Family Members & Ages: \_\_\_\_\_

Home Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Fax Number \_\_\_\_\_ Leave Message at Home? Yes \_\_\_ No \_\_\_ Leave Message at Work? Yes \_\_\_ No \_\_\_

E-mail Address \_\_\_\_\_ Web-page or My Space \_\_\_\_\_

Employer's Name \_\_\_\_\_ Address \_\_\_\_\_

Job Title \_\_\_\_\_ Length of time employed by this employer \_\_\_\_\_

Referred by: \_\_\_\_\_ Phone: \_\_\_\_\_

Religious Background: \_\_\_\_\_

Church: \_\_\_\_\_ Address: \_\_\_\_\_

Pastor: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Psychiatrist: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Conditions: \_\_\_\_\_

Allergies: \_\_\_\_\_

Highest Level of Education: \_\_\_\_\_ Major \_\_\_\_\_

Schools graduated from \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Have you ever filed for bankruptcy? \_\_\_ ... been involved in a lawsuit? \_\_\_ ... been incarcerated? \_\_\_

Medication Currently Taken (include vitamins, minerals and other nutritional supplements): \_\_\_\_\_

Current Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Eyes: \_\_\_\_\_ Hair: \_\_\_\_\_

Previous Therapy? Yes \_\_\_ No \_\_\_ Former Therapist: \_\_\_\_\_

Describe the benefit of your previous therapy \_\_\_\_\_

Medical History:

Hospitalizations:

Military History:

# CONSENT TO COUNSELING

I, the undersigned, am requesting counseling and / or consultation services by

**Dr. Harry L. Morgan**

Suite 1-B  
825 4<sup>th</sup> Street West  
Palmetto, FL 34221

This authorizes Dr. Morgan to provide consultation and referral services. I have been informed of the nature and purposes of this service, and that my consent can be revoked in writing prior to, and / or during the consultation period.

I have read and fully understand the above authorization for counseling / consultation. No guarantee or assurance has been made to me as to any of the results that may be obtained from these services. This is a release of any and all liability to Dr. Morgan and his staff from any decisions or actions that I may or may not take as a result of the counseling I receive at this center.

I give consent to release the information provided during my therapeutic evaluation and counseling sessions for the duration of my counseling to be shared with Dr. Marv Hendon, the Biblical Counseling Center clinical supervisor.

Client's Signature: \_\_\_\_\_

Signature of Parent or Guardian if client is under 18 \_\_\_\_\_

Staff Signature: \_\_\_\_\_

**Furthermore, I have received a copy of the LMHC Intern – Client Services Agreement in compliance with HIPAA.**

Client's Signature: \_\_\_\_\_

Signature of Parent or Guardian if client is under 18 \_\_\_\_\_

I want to receive the Biblical Counseling Center's monthly newsletter in my email.

Date: \_\_\_\_\_

# PERSONAL HISTORY / PROBLEM EVALUATION

## BASIC PROBLEM IDENTIFICATION

*Please check any of the follow symptoms or conditions you have had or are now experiencing.*

<u>CONDITION:</u>	<b>PAST</b> <small>More than 6 months</small>	<b>PRESENT</b> <small>Less than 6 months</small>	<u>CONDITION:</u>	<b>PAST</b> <small>More than 6 months</small>	<b>PRESENT</b> <small>Less than 6 months</small>
Mood high & lows	_____	_____	Physical abuse from others	_____	_____
Weight loss or gain	_____	_____	Sexual abuse from others	_____	_____
Appetite changes	_____	_____	Insomnia (can't sleep)	_____	_____
Drug usage (description _____) (amount per week _____)	_____	_____	Excessive worries	_____	_____
Cigarette smoking	_____	_____	Difficulty concentrating	_____	_____
Tobacco usage	_____	_____	Hearing unseen voices	_____	_____
Irritability	_____	_____	Frequent loss of temper	_____	_____
Excessive stress	_____	_____	Acting out violence	_____	_____
Crying spells	_____	_____	Frequent residence changes	_____	_____
Phobias or fears	_____	_____	Frequent employment changes	_____	_____
Hallucinations	_____	_____	Bed wetting past age 6	_____	_____
Confusion	_____	_____	Fire setting past age 6	_____	_____
Low self-esteem	_____	_____	Blaming others frequently	_____	_____
Compulsive behaviors	_____	_____	Lack of sexual desire	_____	_____
Depression	_____	_____	Spiritual confusion	_____	_____
Extreme nervousness	_____	_____	Thoughts of suicide	_____	_____
Lack of Motivation	_____	_____	Difficulty reading	_____	_____
Alcohol Consumption (description _____) (amount per week _____)	_____	_____	Inability to comprehend math	_____	_____
Indecisiveness	_____	_____	Inability to express yourself	_____	_____
Loss of memory	_____	_____	Involvement with the occult	_____	_____
Fantasizing	_____	_____	Use of pornography	_____	_____
			Physical abuse of children	_____	_____
			Sexual abuse of children	_____	_____
			Physical abuse of others	_____	_____
			Excessive sexual activity	_____	_____

1. When (approximately) did you have a complete physical examination? \_\_\_\_\_ Where? \_\_\_\_\_

2. What physical disorders do you have, if any? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

3. Describe your current relationship to God. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## **BACKGROUND INFORMATION**

*(Briefly Answer the Following)*

1. Identify and describe the problem as best as you can.
2. What have you done to resolve the problem?
3. What are you seeking from this counseling?
4. What immediate circumstances have led to your making this appointment?
5. What additional information do you think would be helpful to the counselor?