FLORIDA COUNSELING FOUNDATION COUNSELING SERVICES

Roger Shepherd and Associates

CONFIDENTIAL INTAKE FORM

GENERAL INFORMATION

Full name: _____ Date: _____

Ethnicity: ❑ Asian ❑ Biracial/bicultural ❑ Black/African American ❑ Caucasian ❑ Hispanic/Latino ❑ Other

Sex: ❑ Male ❑ Female Date of birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip code: _____

Cell phone _____ Call you here? ❑ Yes ❑ No
Message here? ❑ Yes ❑ No
Text Message OK? ❑ Yes ❑ No

Home Phone_____ Call you here? ❑ Yes ❑ No
Message here? ❑ Yes ❑ No

Work phone _____ Call you here? ❑ Yes ❑ No
Message here? ❑ Yes ❑ No

Email:_____ Contact you here? ❑ Yes ❑ No

Employer:_____ How long have you been there:_____

Occupation: _____ Average hours worked per week: _____

Highest level of education completed: _____ Are you currently in school? ❑ Yes ❑ No

If yes, what level?_____ Degree pursuing: _____

In case of emergency, contact:

Name: _____ Relationship: _____

Home phone: _____ Cell phone: _____

How did you hear about us?

❑ Website ❑ Friend ❑ Relative ❑ Pastor ❑ Referred by another counselor

❑ From Christian Sharing Center (If you check this box you are giving The Christian Sharing Center permission to know that you are receiving counseling from Florida Counseling Foundation—and you understand that special arrangements have been made for payment for your sessions)

RELATIONAL INFORMATION

Relationship status: ❑ Single ❑ Dating ❑ Engaged ❑ Married ❑ Separated ❑ Divorced
❑ Widowed ❑ Cohabitating and unmarried ❑ Partnered ❑ Unsure

How long have you been that status? _____

Number of previous marriages for you?_____For your partner/spouse? _____

Spouse's name: _____ Spouse's age: _____

Is your spouse supportive of you seeking counseling? ❑ Yes ❑ No ❑ Unsure ❑ Spouse doesn't know

With whom do you currently live? (*Check all that apply*) ❑ Alone ❑ Spouse ❑ Children ❑ Parent(s) ❑ Sibling(s)
❑ Boyfriend ❑ Girlfriend ❑ Roommate ❑ Other: _____

List your children (including step, adopted, foster, deceased) below:

Name	Sex	Age or year of death	Relationship to you	Living with whom?

Have you ever placed a child for adoption? ❑ Yes ❑ No. If Yes, when? _____

Have you ever had a ❑ miscarriage or ❑ medical abortion? ❑ Yes ❑ No. If Yes, when _____

List your mother, father, brothers, sisters, step-family relations, or any other family member who had a significant effect (positive or negative) upon your life.

Name	Age or year of death	Relationship to you	Give 2-3 words to describe this person

COUNSELING HISTORY

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the names of the therapists or programs: *(Use the back, if necessary*)

Therapist's name or program	Major issue(s)	Dates/Number of Sessions

MEDICAL HISTORY

List any medical conditions, illnesses, treatments, or surgeries:

_____

_____

_____

Your height: _____ your weight: _____

How has your weight changed in the last 2-3 months: ❑ little or no change ❑ up _____lbs. ❑ down _____ lbs.

List all current medications you are taking, including those you seldom use or take only as needed:
(Use back if necessary)

Doctor & Name of medication	Dose	Reason for taking medication

Are you presently experiencing any suicidal thoughts? ❑ Yes ❑ No
Have you experienced them in the past? ❑ Yes ❑ No
Have you ever attempted suicide? ❑ Yes ❑ No
If Yes, when and how:_____

Have any of your ❑ friends or ❑ family ever committed or attempted suicide? ❑ Yes ❑ No
If yes, when and who: _____

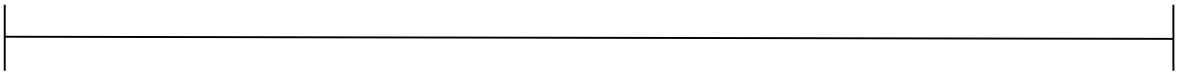
Are you presently experiencing any thoughts of harming yourself or another person? ❑ Yes ❑ No

PRESENT ISSUES

Check any of the following symptoms or problems that you are presently experiencing or have experienced in the past.

Past/Present	Past/Present	Past/Present
❑ ❑ Stress	❑ ❑ Fears	❑ ❑ Controlled by others
❑ ❑ Anxiety or worry	❑ ❑ Shyness	❑ ❑ Obsessive thoughts
❑ ❑ Panic	❑ ❑ Low self-esteem	❑ ❑ Compulsive behaviors
❑ ❑ Depression	❑ ❑ Don't like myself	❑ ❑ Seeing things others don't see
❑ ❑ Crying all the time	❑ ❑ Marital problems	❑ ❑ Hearing voices
❑ ❑ Lack of motivation	❑ ❑ Other relational problems	❑ ❑ Racing thoughts
❑ ❑ Fatigue/Lack of energy	❑ ❑ Parenting problems	❑ ❑ Eating problems
❑ ❑ Poor appetite or overeating	❑ ❑ Physical abuse	❑ ❑ Drug use
❑ ❑ Trouble sleeping	❑ ❑ Emotional abuse	❑ ❑ Alcohol use
❑ ❑ Poor concentration	❑ ❑ Verbal abuse	❑ ❑ Pregnancy
❑ ❑ Feeling worthless or inferior	❑ ❑ Sexual abuse	❑ ❑ Abortion
❑ ❑ Feeling hopeless	❑ ❑ Sexual problems	❑ ❑ Legal matters
❑ ❑ Guilt	❑ ❑ Gender identity	❑ ❑ Work stress
❑ ❑ Death of friend or loved one	❑ ❑ Anger	❑ ❑ Career choices
❑ ❑ Grief	❑ ❑ Aggressive behavior	❑ ❑ Indecisiveness
❑ ❑ Chronic pain	❑ ❑ Bad dreams	❑ ❑ Lack of discipline
❑ ❑ Physical disability	❑ ❑ Unwanted memories	❑ ❑ Financial problems
❑ ❑ Terminal illness	❑ ❑ Loss of control	❑ ❑ Spiritual apathy
❑ ❑ Health concerns	❑ ❑ Impulsive behavior	❑ ❑ Other_____
❑ ❑ Loneliness	❑ ❑ Controlling	❑ ❑

Please use an "X" on the scale below to indicate how distressing your problem(s) are to you.



Minimally Distressing | Moderately Distressing | Extremely Distressing

Please describe why you are coming to counseling *(i.e., what are your issues, problems?)*:

_____
_____
_____

Why have you decided to come for counseling now?

_____
_____
_____

What do you hope to gain or change by coming for counseling?

_____
_____
_____

TERMS OF SERVICE

I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of intention to cancel, I will be charged the full administrative fee for service.

Signed: _____ Date: _____