



CLIENT INTAKE FORM

Counselor's Name: _____ Date ____/____/____ Client ID: _____

Client's Name _____ DOB ____/____/____ SSN:____ - ____ - _____

Parent/guardian name (for minor clients under 18 yrs) _____

Home address: _____ City _____ State ____ Zip _____

Marital status: ____ single ____ married ____ divorced ____ widowed ____ separated

Home phone number _____ Work phone number _____

Leave message at home ____Y ____N Leave message at work ____Y ____N

Cell phone number _____ whose cell? _____

Emergency Point of Contact: Name _____ Phone Number _____

Employer's name _____ Address _____

Referred by: _____ Physician _____

Phone # _____

Medical conditions: _____

Past medications and dosage: _____

Current medication and dosage: _____

Allergies: _____

Previous Therapy ____Y ____N Former Therapist/Treatment Center _____

Was your previous therapy helpful ____Y ____N

What problems are you seeking counseling for now? _____

Person who is financially responsible for today's visit _____

Billing address if different from client _____

Billing Phone Number: _____

Today's visit will be paid by ____ Credit Card ____ Cash ____ Check Payable to COUNSELOR

The counselor may discuss my case with the following people: _____

Client's Signature _____ Date ____/____/____

(Guardian/Parent signature if under 18)

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CONSENT TO TREATMENT AND CONFIDENTIALITY

I, _____, request counseling and/or consultation services from GHP Counseling Services.

I hereby authorize the counseling staff of the above stated facility to provide consultation and referral services. I have been informed of the nature and purpose of this service and that my consent can be revoked orally or in writing prior to, and or, during the consultation period. I have read and fully understand the above authorization of counseling/consultation. No guarantee or assurance has been made to me as to any of the results that may be obtained from these services. I hereby release from any and all liability the staff, counselors, and employees of the above mentioned center from any and all decisions and actions that I may or may not take as a result of the counseling I receive at this center. I understand that Christian Counseling is spiritual, not medical, in nature.

Check One:

I request Christian counseling _____ I don't request Christian counseling _____

Client's signature _____ Dated ____ / ____ / ____
 (Guardian/Parent signature if under 18)

You may send my treatment plan to my primary care physician: _____Y _____N

If not please give reason:



Background Information

Please check any of the following symptoms or conditions you have had or are now experiencing:

CONDITION	Past	Present	CONDITION	Past	Present
Mood highs and lows			Insomnia (can't sleep)		
Weight loss or gain			Excessive worries		
Appetite changes			Difficulty concentrating		
Drug usage			Hearing unseen voices		
Cigarette smoking			Frequent loss of temper		
Tobacco usage			Acting out in violence		
Irritability			Frequent residence changes		
Excessive stress			Frequent employment change		
Crying spells			Bed wetting past age 6		
Phobias or fears			Fire setting past age 6		
Hallucinations			Blaming others frequently		
Confusion			Lack of sexual desire		
Low of self esteem			Spiritual confusion		
Compulsive behaviors			Thoughts of suicide		
Depression			Inability to comprehend reading		
Extreme nervousness			Inability to comprehend math		
Lack of motivation			Inability to express yourself		
Excessive drinking			Involvement with the occult		
Indecisiveness			Use of Pornography		
Loss of memory			Physical abuse of children		
Fantasizing			Sexual abuse of children		
Sexual abuse from others			Physical abuse of others		
Physical abuse of others			Excessive sexual activity		
Abortion			Drug Use / Addiction		
Divorce			Loss of loved one		

1. How long has it been since you had a complete physical examination? _____
2. Other physical issues the therapist should be aware of: _____



GHP Counseling Services
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PERSONAL HISTORY / PROBLEM EVALUATION

BASIC PROBLEM IDENTIFICATION

(Briefly answer the following)

1. DESCRIBE THE PROBLEM THAT BRINGS YOU HERE TODAY:
2. WHAT HAVE YOU DONE ABOUT IT SO FAR?
3. WHAT DO YOU HOPE TO GAIN FROM THIS COUNSELING?
4. WHAT CIRCUMSTANCES HAVE LED TO YOU COMING HERE TODAY?
5. IS THERE ANY OTHER INFORMATION THAT YOU THINK THE COUNSELOR SHOULD KNOW?