Biblical-Christian Counseling Services Client Intake Form

Name: ____ Today's Date: __________________

DOB ________________________ Age ______ Is client under 18 years of age? Yes ♦ No ♦

Name of Person filling out this form and reason: ____
____

Address: ____________________________ City: ________________ ST: ______ Zip: _________

Mailing Address (if different): ____
Phone: (C) ______________________ (H) ____________________ (W) _____________________

Email: ____

May we leave a voice/text message? Yes ♦ No ♦ If yes, by ♦ cell ♦ home ♦ work ♦ email

May we send you an appointment reminder? Yes ♦ No ♦ If yes, by ♦ text ♦ v-mail ♦ email

Employer: _____________________________ Occupation: _______________________________

Are you a student? Yes ♦ No ♦ If yes, name of school: ___________________________________
Emergency Contact: _________________ Relationship: ____________ Phone: ______________
Referred by: ______________________________ May we send them a thank you? Yes ♦ No ♦
Presenting Problem/Issues Briefly describe the problems or issues that brought you to counseling:
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____
____

When did these problems or issues develop? ____
____
____

What are you hoping to achieve through counseling? ______________________________________
____
____

Client Problem Assessment Presenting Problem – Precipitating Stressors:

"In recent months, I have been concerned about…" Please check all that apply, past or present

♦ Marriage ♦ Spouse/Partner ♦ Parent/Child ♦ Family of Origin ♦ Extended Family ♦ Abuse ♦ physical ♦ sexual ♦ psychological ♦ neglect) ♦ Guilt ♦ Shame ♦ Cultural/Ethnic/Race ♦ Health ♦ Job ♦ Financial Other: __________________________________

Symptoms: Please check all that apply: ♦ Decreased Concentration ♦ Decreased Motivation ♦ Decreased Energy ♦ Disturbance in Sleep Patterns ♦ Increased Stress ♦ Loss of Control ♦ Decreased Interest in Activities ♦ Numbness or Tingling ♦ Chest Pains / Discomfort ♦ Unexplained Physical Problems ♦ Body Tension ♦

Thoughts of Death/Suicide Other

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Major Life Events

Please check all that apply: ♦ Death of a family member/friend ♦ Divorce ♦ Separation ♦ Imprisonment ♦ Personal injury/illness ♦ Marriage ♦ Job loss ♦ Pregnancy/complications ♦ Career change ♦ Legal problems ♦ Relocation ♦ Holidays ♦ Financial Other:

____

Suicidal / Homicidal Ideation Have you attempted to commit suicide or homicide in the past? Yes ♦ No ♦ Is there a history of suicide/homicide in your nuclear and/or extended family? Yes ♦ No ♦ Are you presently suicidal/homicidal? Yes ♦ No ♦ If yes, explain (how, when, where, what method, why):

____

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Have you ever subjected yourself to harm such as cutting, hitting, or burning? Yes ♦ No ♦ Have you ever subjected another person to physical harm? Yes ♦ No ♦ If yes, explain (how, when, where, what method, why): ____

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Strengths and Weaknesses Please list what you consider to be your personal strengths and weaknesses.
Strengths Weaknesses __________________________________ __________________________________

__________________________________ __________________________________

__________________________________ __________________________________

__________________________________ __________________________________

__________________________________ __________________________________

__________________________________ __________________________________

Living Arrangements Current Address: ____

How Long: ___________ With whom do you live?
____ Current relationship with others where you live: ____

____

____

Relationship History Sexual Orientation:

____

Are you married? Yes ♦ No ♦ If not married, are you in a relationship? Yes ♦ No ♦

Name and age of spouse/partner: ____

Date of marriage/cohabitation: ____

Previous marriage/relationship: Yes ♦ No ♦ If yes, name of spouse/partner: __________________

If yes, date of divorce/end of partnership: ____

Where children involved in the previous marriage/partnership: Yes ♦ No ♦ What is your perception of the status of your current relationship? (include communication patterns and problems, relationship issues, blended family issues, sexual relations, etc.) _______________________________

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Name, ages, and relational history of children from marriages/partnerships. Name Age Comments Bio, Step, Adopted _________________ ______ ________________________ _______________________

_________________ ______ ________________________ _______________________

_________________ ______ ________________________ _______________________

_________________ ______ ________________________ _______________________

_________________ ______ ________________________ _______________________

_________________ ______ ________________________ _______________________

Developmental History List the members of your family of origin/adoption and your compatibility with each one now. Family Member Comments ______________________________

____ ______________________________

____ ______________________________

____ ______________________________

____ ______________________________

____ ______________________________

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What was your birth order: # ____ of ____ children. Who primarily raised you? _________________
How would you describe your childhood? ♦ Uneventful ♦ Boring ♦ Traumatic ♦ Painful ♦ Unhappy ♦ Ignored ♦ Neglected ♦ Withdrawn ♦ Other _________

What was life like for you as a child? (Include what you were like as a child, relationship with parents, siblings, family, and friends; hobbies, and personality.)

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____

____

Did you experience any traumatic events as a child or adult? (Include serious illness/injuries, surgeries, death of family and/or friends, natural disasters, abuse, neglect, etc.) Date Age Event ____________

_______ ____ ____________ _______

____ ____________ _______

____ ____________ _______

____ ____________ _______

____ ____________ _______

Support System Who do you depend on for support? (Check all that apply) ♦ Parents ♦ Siblings ♦ Spouse ♦ Children ♦ Employer ♦ Church ♦ Pastor ♦ Therapist ♦ Extended Family ♦ Neighbor(s) ♦ Close Friend(s) ♦ Co-Worker(s) ♦ Doctor(s) ♦ Support Group(s) ♦ Community Services ♦ Other: _______________

Family Involvement Would it be beneficial for any members of your family to be involved in your treatment? Yes ♦ No ♦ If yes, explain who and why (complete release of information consent form if needed): ____
____
____

Legal History (Please explain all that apply, past and present) Charges as a minor: ____

Current Charges: ____
Arrests: ____
Convictions: ____
Parole/Probations: ____
Bankruptcies: ____
Divorce/Separation: ____
Foreclosures: ____

Civil Suits: ____

Financial Situation Briefly describe your financial situation: ____
____
____

Work History Describe your current job/career: ____
____

What do you like or dislike about your job and/or career? Like Dislike

____________________________________ ____________________________________
____________________________________ ____________________________________
____________________________________ ____________________________________
____________________________________ ____________________________________

How do you deal with authority figures? Describe your relationship with supervisors and co-workers.
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____

Have you ever been fired from a job? Yes ♦ No ♦ If so, please explain: ______________________
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Educational History Describe what school was like for you:

____
____
Highest level of education: __________________ What kind of grades did you make? _____________

Military History (Please include branch, rank, activity, deployments, awards, achievements, discharge status, etc.)

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____
Religious and Cultural Factors Please list any issues, values, or beliefs which are important or may have affected you regarding your religion or cultural/ethnic background:

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____
____

Do you have a religious/spiritual background? Yes ♦ No ♦ Preference ________________________

Do you attend religious/spiritual services? Yes ♦ No ♦ If so, where and how often? ____________
____

Medical History How would you describe your current health?

____

Are you currently on medications? Yes ♦ No ♦

If yes, please provide information. Name of Medication Dosage/Frequency Prescribing Physician

_____________________ _____________________ __________________________
_____________________ _____________________ __________________________
_____________________ _____________________ __________________________
_____________________ _____________________ __________________________

Has it been more than a year since your last physical exam, including blood work? Yes ♦ No ♦ Have you had or were you involved with an abortion? Yes ♦ No ♦ Miscarriage? Yes ♦ No ♦

List any previous health issues including surgeries, procedures, and medical hospitalizations: Problem Date Treatment ____________________________ _________ __________________________________
____________________________ _________ __________________________________
____________________________ _________ __________________________________
____________________________ _________ __________________________________

Counseling History (Please list all previous psychotherapy experiences.) Are you or have you ever participated in counseling or psychotherapy treatment? Yes ♦ No ♦

If yes, please provide as much information as possible. Date(s) Provider Reason for Treatment Results

___________ ____________________ _________________________ _____________________
___________ ____________________ _________________________ _____________________
___________ ____________________ _________________________ _____________________
___________ ____________________ _________________________ _____________________

Psychiatric History

(Please list all previous inpatient / outpatient experiences.) Have you ever been treated by a psychiatrist/psychologist for a mental health issue? Yes ♦ No ♦

Have you ever been hospitalized for mental health related issues? Yes ♦ No ♦

Have you ever been hospitalized for mental health issues related to substance abuse? Yes ♦ No ♦

If you answered yes to any of the above, please provide as much information as possible. Date(s) Provider Reason for Treatment Results ___________ ____________________

_________________________ _____________________ ___________ ____________________
_________________________ _____________________ ___________ ____________________
_________________________ _____________________ ___________ ____________________
_________________________ _____________________ ___________ ____________________
_________________________ ____________________

List all psychotropic medications you have taken including those for anxiety, depression, and/or sleep:
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Has anyone in your family ever been diagnosed or treated for a mental health disorder, alcohol or drug related problem? Yes ♦ No ♦ If yes, please explain.

Has anyone in your family had problems with alcohol or drugs that was not treated? Yes ♦ No ♦ If yes, please explain. Family member Problem/Disorder Treatment Results (if any) __________________

_______________________ _____________________________________ __________________
_______________________ _____________________________________ __________________
_______________________ _____________________________________ __________________
_______________________ _____________________________________ __________________
_______________________ _____________________________________

Substance Use / Abuse History Describe your history of current/past substance usage (including OTC, prescription, alcohol, caffeine, and tobacco). Substance Amount Frequency Age of 1st use Age regular use started Age last used _______ _____ _______ _________ ________________ ______ _______
_____ _______ _________ ________________ ______ _______ _____ _______ _________
________________ ______ _______ _____ _______ _________ ________________ ______ _______

Have you experienced an increase in the use of alcohol and/or other substances? Yes ♦ No ♦ Do you see your usage as a problem? Yes ♦ No ♦ If yes, when did it become problematic?

____

____

Please describe any previous experience with substances or alcohol ___________________________

____

____

Please describe any family history of substance and/or alcohol use ___________________________

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____

Do you or any of your family have compulsive or addictive behaviors such as gambling, sexual behavior, shopping, etc.? Yes ♦ No ♦ If so, please describe ______________________________

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____

Nutrition Have your eating habits changed recently? Yes ♦ No ♦ If so, please describe

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____

Has your weight fluctuated more than +/- 10 lbs. over the previous year? Yes ♦ No ♦ Do you often eat out of depression, boredom, and/or anger? Yes ♦ No ♦ If yes, please describe

____

Do you use laxatives, water pills (diuretics), or diet medications? Yes ♦ No ♦ If so, how often and for what purpose do you use them? ____

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Additional Information Is there any other information that can be helpful for us to know about you?

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____ ____________________________

Client Signature__________________________________ Date___________________

INFORMED CONSENT FOR TREATMENT & HIPAA GUIDELINES CONFIDENTIALITY

All sessions are completely confidential in accordance with law and recognized professional standards. If your therapist needs to communicate with another about your case, you must give written permission to do so. The only exception to this is, if in accordance with law such communication appears needed to protect you or others from harm or in response to legal process, or in other proper circumstances, the privileged nature of your communication ceases. Possible exceptions include, but are not limited to, the following situations: child abuse, abuse of the elderly or disabled, threats of suicide or homicide. The "Health Insurance Portability and Accountability Act (HIPAA)" provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care.

Dr. Paul Waldmiller provides a biblically based counseling, integrating with Christian principles. Therapy is an interactive process between client and therapist, and the results of therapy depend heavily on your cooperation. It is meant to promote change and understanding. Sometimes this process can be emotionally painful, and at other times, very fulfilling. You will be expected to contribute to all decisions regarding therapeutic intervention devised for you, including out of session assignments. You have the right to refuse or alter any service and intervention. While we will use our best efforts to assist you, the nature of therapeutic and counseling services is that there can be no assurances of results, and no promises can be made regarding the outcome of any services provides.

Dr. Waldmiller's FEES/PAYMENT are based on 50-60 minute sessions. Payment is due at the time of service. FEE amount is by donation only. The suggested donation is $45 per session.

VERY IMPORTANT**If you are unable to keep an appointment, please notify Dr. Waldmiller immediately.

RESPONSIBILITY I voluntarily agree to receive mental health assessment, care, treatment or services and authorize my therapist to provide such. I understand and agree that I will participate in the planning of these services and that I may stop such care at any time. I acknowledge that I have read and understand my HIPPA rights and consent for treatment.

Client Signiture____ Date____________

Be sure to sign and then return original copy to Dr. Paul Waldmiller before Counseling sessions begin...
Paul@gfom.org