GRACE & PEACE
COUNSELING

Intake Information

Date: _____

Name: _____ Spouse/Partner's Name:_____

Address: _____

Date of Birth _____ Age _____ Email address _____

Telephone – Home:_____ Work/Cell: _____

1. Sex ☐ Male ☐ Female

2. Marital/Relationship Status
- ☐ Single (never married)
- ☐ Significant Other
- ☐ Cohabitating (living together)
- ☐ First Marriage
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Remarried (after divorce)
- ☐ Remarried (after spouse's death)

3. Current Employment
- ☐ Full-time
- ☐ Part-time
- ☐ Homemaker
- ☐ Unemployed
- ☐ Full-time student
- ☐ Part-time student
- ☐ Retired

4. Education
- ☐ grade school/junior high
- ☐ attending/attended high school
- ☐ High school graduate
- ☐ Attending/attended college
- ☐ College graduate
- ☐ Attending/attended graduate school
- ☐ Technical school degree
- ☐ Graduate degree (Masters)
- ☐ Graduate degree (Doctoral)

5. Children (include biological, adopted, foster, step, etc)

Name	Sex	Age	Type (bio,step,etc.)	Custody?
_____	_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	_____	☐ Yes ☐ No

6. Race/Ethnicity
- ☐ Caucasian
- ☐ African American
- ☐ Latin or Spanish
- ☐ Native American
- ☐ Asian
- ☐ Multiracial
- ☐ Other _____

7. Are you presently under a physician's (or psychiatrist's) care? ☐ Yes ☐ No

If yes, what for? _____

_____

List current medications and amounts _____

_____

Name and address of physician _____

_____

Initial Service Plan

Please check any of the reasons listed below which resulted in your coming in today:

- ☐ Depression or Anxiety
- ☐ Alcohol or other drug abuse
- ☐ Marital Problems
- ☐ Communication Difficulties
- ☐ Improved Sexual Relations
- ☐ Sexual Orientation Questions
- ☐ Child Adjustment/Parent Conflict
- ☐ Divorce
- ☐ Adoption
- ☐ _____
- ☐ Difficulty with loss or death
- ☐ Thinking of harming self or others
- ☐ School learning difficulties
- ☐ Family Counseling
- ☐ Relationship Enhancement
- ☐ Abuse (physical/verbal/sexual)
- ☐ Individual Counseling
- ☐ Pre-marital Counseling
- ☐ School adjustment problems
- ☐ _____

What event happened which made you think "I am (we are) calling a therapist?" _____

_____

_____

Please explain what you are hoping to achieve through the use of counseling services:

_____

_____

_____

What behaviors would you like to change? _____

_____

_____

How would you know if things were getting better? _____

_____

_____

Specific Goals identified after first session (to be completed with therapist)

_____

_____

_____

Patient Signature _____ Date _____

_____ Date _____

Therapist Signature_____ Date _____

Have you received prior counseling? Y or N related to these problems? _____ Other _____

If yes and related, was it: Outpatient Inpatient (hospitalization)

When:_____ Where: _____

Counselor/Doctor: _____ Length of Treatment:_____

Problem(s) treated: _____

Outcome: ☐ Very Successful ☐ Somewhat Successful ☐ Stayed the Same ☐ Somewhat Worse ☐ Much Worse

If Other, was it: Outpatient Inpatient (hospitalization)

When:_____ Where: _____

Counselor/Doctor: _____ Length of Treatment:_____

Problem(s) treated: _____

Outcome: ☐ Very Successful ☐ Somewhat Successful ☐ Stayed the Same ☐ Somewhat Worse ☐ Much Worse

Family History of mental illness? (if yes, please describe)_____

_____

_____

How were you referred to me? _____

Person to contact in case of an emergency:

Name _____Relationship _____
Address _____
Phone: Home _____ Work/Cell _____