Westside Christian Counseling Center

Adult Clinical Intake

Each person participating in therapy is asked to complete this form as this will expedite the counseling process. This information will remain confidential.

Client First Name: ____________________________ Last Name: ___________________________ MI: _______
Client DOB: _____/_____/_____ SSN#: _____________________________ Date: _____/_____/______
Address: _____________________________________ City: _______________ State: ______ Zip: ___________
Home Ph: ______________________ Work Ph: _____________________ Cell Ph: ______________________
Employed at: ______________________________
Emergency Contact Name: __________________________________ Phone#: _____________________________
How did you hear about us? _________________________________ Referred by: _________________________
Currently involved in church? □ yes / □ no If yes where and how frequently: ______________________________
Ethic Origin: ____________________________________ Gender: male □ female □
Responsible Party: ____

Insurance:
Ins Company: __________________________________ Client Insurance ID #:____________________________
Policy Holder Name: _______________________________ Policy Holder ID #: ___________________________
Policy Holder DOB: ______/______/_______ Policy Holder Address (if different): ___________________________
Policy Holder ID #: _______________________________ Policy Holder Address: _______________________
Gross Yearly Income of Household: <25,000 □ <50,000 □ <75,000 □ >75,000 □

Relationship Status: single □/ married □ / divorced □/ widowed □/ separated □/ living with someone □
If married or living with someone please answer the following:
Name: __________________________________ DOB: _____/_____/_____ SSN#: ________________________
Ethic Origin: ____________________________________ Gender: male □ female □
Do you have child(ren)? □ yes / □ no If yes, provide information below:

Name | Age/DOB | Describe Your Relationship With Them

____
____
____
____
____

Educational Background: GED □ HS Diploma □ Bachelor's Degree □ Graduate Degree □
Post Graduate Degree □ other □ If degree or training please specify here:___________________________
Schools: ____

History:

Employer | Dates of Employment | Reason for Leaving

____
____
____

Do you have any developmental delays? □ yes / □ no If yes, describe:______________________________
Have you experienced past trauma? □ yes / □ no If yes, describe:__________________________________
Do you have any medical issues? □ yes / □ no If yes, describe:____________________________________
Date of last medical exam:___________________ Medical doctor and phone #:_____________________

Psychiatric History:
Have you attended counseling previously? □ yes / □ no If yes, specify the following:

Dates | Where and With Whom | Presenting Issues | Diagnosis Given

____
____
____

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Psychotropic Medications:
Are you currently taking any psychotropic medications? □ yes / □ no (Specify current and past meds)

Medication	Dosage	Dates of Usage	Prescribed for What	Physician

____
____
____
____

Alcohol/Drug/Smoking/Eating Disorders Issues:
Do you currently have any of the issues listed above or other issues that are not listed? □ yes / □ no
If yes, please describe which one(s) and length of time it has or was an issue:_________________________
____
Have you had these issues in the past? □ yes / □ no If yes, please describe which one(s) and length of time it has been an issue:____

Abuse History:
Have you ever been physically, emotionally, verbally, or sexually abused? □ yes / □ no
If yes, please describe which one(s) by whom and when:____

Legal History:
Have you ever been arrested? □ yes / □ no If yes, for what and when:______________________________
Are you currently on probation or parole? □ yes / □ no If yes, for what and when:_____________________

Suicide Risk:
Have you ever thought about or tried to hurt yourself? □ yes / □ no
If yes, how and when?____
____
Has anyone close to you ever committed suicide? □ yes / □ no If yes, who, when and how:_____________
____

Check the following symptoms/behaviors that you have experienced in the last 30 days:

- □ Trouble sleeping
- □ Sleep too much
- □ Withdraw from people
- □ Nightmares
- □ Easily Irritated/Annoyed
- □ Cry excessively
- □ Excessive Negativity
- □ Aggressive toward others/Blaming
- □ Decreased sex drive
- □ Feeling others watching you
- □ Weight Change
- □ Eat too much/too little
- □ Stomachaches
- □ Feel down/depressed
- □ Guilt/Sorry/Shame
- □ Panic Attacks
- □ Trouble concentrating
- □ Difficulty making decisions
- □ Increased sex drive
- □ Hard to be under authority
- □ Low Motivation/lack of
- □ Feel tension/stressed
- □ Headaches
- □ Anxious
- □ Cruelty to Animals
- □ Fearful
- □ Self Harm
- □ Temper/Outbursts
- □ Feel paranoid
- □ Do not respect others

Support Systems: Do you have people that you can turn to for support? □ yes / □ no
If yes, who and where do they live? ____

Strengths: What do you feel are your strengths?____
____

Presenting Issues: Briefly explain why you are seeking counseling at this time: ________________________
____
____

Goals: What do you hope to achieve through counseling? ____
____
____