NORTHWEST
CHRISTIAN COUNSELING, LLC

NEW CLIENT -- INTAKE INFORMATION

Client name: _____ Today's Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of birth: _____ Age: _____

(NOTE: if client is a minor, NWCC must have a signed consent form from both parents/guardians, or the parent/guardian who has court authorization to make medical decisions for the minor).

Living Situation (who do you live with?): _____

Home phone: _____ OK to leave message/voicemail/text? Y / N

Cell/Message phone: _____ OK to leave message/voicemail/text? Y / N

Email address: _____

□ check if OK to communicate via email. (NOTE: confidentiality cannot be guaranteed for email communication.)

Family Status (use reverse side of form if necessary):

Member	Name	Occupation	Age	Notes/Comments
You				
Spouse/Sig. Other				How long married?
Children				
Parent/Guardian 1				
Parent/Guardian 2				
Siblings				
Previous Marriage(s)?				How many yrs married?

Medical Doctor: _____ Phone: _____

Emergency contact person: _____ Phone: _____

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INTAKE INFORMATION (PAGE 2)

Client name: _____ Today's Date: _____

Reason for counseling: _____

_____

Symptoms Checklist (please check any symptoms that you are currently or recently struggling with):

- □ Family/marriage/relationship
- □ Pre-marital
- □ Sexual addiction/sexuality
- □ Substance abuse
- □ Mood changes
- □ Anger/irritability
- □ Fear/worry/anxiety
- □ Depression
- □ Danger/harm to self/others
- □ Self-esteem/self-worth
- □ Sleep difficulties
- □ Concentration/memory
- □ Weight/body image
- □ Eating disorders
- □ Social/friendships
- □ Work-related issues
- □ Grief/loss
- □ Physical pain/health
- □ Spiritual distress
- □ Obsessions/compulsions
- □ Inattention/Hyperactivity
- □ Other (list):

_____

_____

General Information: (age, ethnicity, religion, marital status, referral status): _____

_____

_____

History of Presenting Problem(s) or Issue(s): (symptoms, onset, duration, frequency, etc): _____

_____

_____

_____

Psychological History (prior treatment, symptoms, diagnoses, hospitalizations, suicide attempts, cutting/self-harm, violent history, etc): _____

_____

_____

Trauma History (nature of trauma, when it occurred, persons involved, etc): _____

_____

_____

Family Psychological History (history of mental illness in family, diagnoses, etc): _____

_____

_____

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INTAKE INFORMATION (PAGE 3)

Client name: _____ Today's Date: _____

Medical Conditions and History (current and past medical conditions, treatments, allergies, etc): _____

_____

_____

Current Medications (medication, dosage, purpose, prescribing physician, etc): _____

_____

_____

Substance Use/Abuse: (substance, start date, last use, amount, frequency, etc): _____

_____

_____

Family History (family of origin, relationship with parents, siblings, and significant others, etc)**:** _____

_____

_____

Social History (significant relationships, social support, nature/quality of relationships, social interests/hobbies etc)**:** _____

_____

_____

Developmental History (developmental milestones, delays, etc)**:** _____

_____

_____

Educational/Occupational History (level of education, current/past employment, etc)**:** _____

_____

_____

Legal History (arrest history, sentencing, DUI information, incarceration, litigation, etc)**:** _____

_____

_____

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INTAKE INFORMATION (PAGE 4)

Client name: _____ Today's Date: _____

Current Stressors (things that cause you worry or stress): _____

_____

_____

How would you describe your eating, sleeping, and exercise habits? _____

_____

_____

Sexual Issues (sexual trauma or abuse, sexual addiction issues, issues/problems related to sex, etc)**:** _____

_____

_____

Spiritual and/or religious information (religion, church involvement, etc): _____

_____

_____

_____ *initial here if you are seeking Christian-based counseling;*
_____ *initial here if you want your counselor to use prayer in counseling.*

What are your strengths and weaknesses? _____

_____

Preliminary Goals for Counseling (what you want to accomplish): _____

_____

_____

_____
Client name (printed)

_____ _____
Client signature Date

_____ _____
Counselor Signature & Credentials Date