Christian Psychological Services

Confidential Intake Form (please complete first and last pages as a minimum)

Date: _____

Patient Name: _____ SSN: _____-_____-____ (needed for Tricare Ins only)

Date of Birth: ___ / ___ / _____ Gender: [ ] Male [ ] Female Ethnicity _____

Home Address: _____
Street

_____
City State Zip

Home Phone Number _____ May we leave a message? [ ] Yes [ ] No

Work Phone Number _____ May we leave a message? [ ] Yes [ ] No

Cell Phone Number _____ May we leave a message? [ ] Yes [ ] No

If the above patient is a minor complete the following:

Name of Guardian: _____

Address of Guardian: _____
Street

_____
City State Zip

Guardian's Home Phone _____ May we leave a message? [ ] Yes [ ] No

Guardian's Work Phone _____ May we leave a message? [ ] Yes [ ] No

Guardian's Mobile Phone _____ May we leave a message? [ ] Yes [ ] No

If you will be using insurance to cover a portion of the cost please complete the following and allow us to make a photocopy of your insurance card:

[Check if Same as Patient □ Insurance Card Holder's SSN: ____-_____-_____ Date of Birth: ___/___/____]

Primary Insurance Company: _____

Secondary Insurance Company if applicable: _____

Referral Source

Who referred you to our office, or how did your learn about our practice? _____

Church affiliation _____ Pastor_____

Emergency Contact Information

In case of an emergency, who should we contact?

Name: _____ Relationship: _____

Phone Number: _____

Christian Psychological Services

History Information

Completing the following information as thoroughly as possible will help your therapist provide you the best treatment.

Who is providing the history information? [ ] The patient [ ] The patient's guardian

[ ] Other: _____

Please describe the current complaint or problem or reason for appointment as specifically as you can, in your own words: _____

_____

How long have you experienced this problem, or when did you first notice it? _____

What stressors may have contributed to the current complaint or problem?_____

_____

Check all words/phrases that describe what you are experiencing and explain if possible.

[ ] Depression/sad/down _____

[ ] High/Low energy level _____

[ ] Angry/Irritable _____

[ ] Loss of interest in activities _____

[ ] Difficulty enjoying things _____

[ ] Crying spells _____

[ ] Decreased motivation _____

[ ] Withdrawing from people _____

[ ] Mood Swings _____

[ ]Change in weight or appetite _____

[ ]Suicidal thoughts or plans _____

[ ] Poor concentration _____

[ ] Feelings of hopelessness _____

[ ] Feelings of shame or guilt _____

[ ] Feelings of being cheated _____

[ ] Feelings of inadequacy _____

[ ] Anxious/nervous/tense _____

[ ] Panic attacks _____

[ ] Racing or scrambled thoughts _____

[ ] Bad or unwanted thoughts _____

[ ] Flashbacks _____

[ ] Muscle tensions, aches, etc. _____

[ ] Hearing voices _____

[ ] Seeing things _____

[ ] Thoughts of hurting people _____

[ ] Thoughts of running away _____

[ ] People are out to get me or hurt me _____

[ ] Feelings of frustration _____

[ ] Indecisiveness about career _____

[ ] Job problems _____

[ ] Sleep problems:_____

Are you currently experiencing thoughts of harming either yourself or someone else? [ ] Yes [ ] No

Have you in the past experienced thoughts of harming either yourself or some one else? [ ] Yes [ ] No

Coordination of Care

It is important for your health care providers to speak to each other so we may work together for your benefit. Please complete the information and indicate your approval for us to coordinate care.

Primary Care Physician:_____ Ph:_____

Psychiatrist/Psychologist/Therapist:_____ Ph:_____

May we contact your Physician: [ ] Yes [ ] No [ ] I Do not have a physician

May we contact your Psychiatrist: [ ] Yes[ ] No [ ] I Do not have a Psychiatrist

May we contact your Psychologist/Therapist: [ ] Yes [ ] No [ ] I Do not have a Psychologist/Therapist

Treatment History

Previous Outpatient counseling and/or psychotherapy? [ ] Yes [ ] No

Additional Information: _____

Previous Psychiatric hospital admissions? [ ] Yes [ ] No

Additional Information:_____

Previous Chemical dependency admissions: [ ] Yes [ ] No

Additional Information:_____

Suicide attempts: [ ] Yes [ ] No How & When? _____

List any current, or past, medications

Medication & Dose	Date	Response
_____	_____	_____
_____	_____	_____
_____	_____	_____

Developmental History

Are you aware of any difficulties or complications during the time your mother was pregnant with you? [ ] Yes [ ] No

If yes, explain: _____

Did you walk, talk, and read on time? [ ] Yes [ ] No, explain: _____

Medical History

History of serious childhood illnesses: _____

Other health concerns, serious illnesses, conditions, or major operations requiring hospitalization during your life time: _____

Have you experienced any head injuries? [ ] Yes [ ] No Important Details: _____

If yes, did you lose consciousness? [ ] Yes [ ] No

Have you experienced convulsions or seizures? [ ] Yes [ ] No If yes, did you also have a fever? [ ] Yes [ ] No

Allergies: [ ] None [ ] Allergic to :_____

How would you rate your current physical health? [ ] Excellent [ ] Very Good [ ] Good
[ ] Fair [ ] Poor [ ] Very Poor

What was the date of your last physical or routine health "check up?" _____

Family History

Birth Location _____ Raised by: [ ] Mother [ ] Father [ ] Step-Mother [ ] Step-Father
[ ] Other: _____

Describe your relationship with parent figures: (good, fair, poor, close, distant, etc)

Mother: _____

Father: _____

Other: _____

Other: _____

List your siblings and describe your relationship with them?

First Name	Age	Gender	Nature of Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any history of neglect, and/or physical, verbal, emotional, spiritual, or sexual abuse?

_____

Any family history of substance abuse, mental illness, suicide, or violence? _____

Any additional family information: _____

Social History

Describe your relationship with peers and/or friends. _____

How would you describe your social support network? _____

Describe your hobbies/interests: _____

Have you ever had concerns about being too "shy" or "timid"; or too "rambunctious" or "loud" socially?_____

_____

Describe any cultural concerns: _____

How important are religious/spiritual issues to you? [ ] Not Important [ ] Average Importance [ ] Very Important

Do you wish to integrate religious/spiritual material (prayer, scripture, etc.) as part of treatment? [ ] Yes [ ] No

Educational History

When attending school where you: [ ] In regular classes [ ] Home Study [ ] Special classes

[ ] Ever suspended, yes for what reasons:_____

What is the highest educational level you have completed?_____

Give any additional important educational information (i.e. Did you like school?):_____

_____

Occupational History

What is your current employment status? [ ] Employed Full-Time [ ] Employed Part-time [ ] Unemployed
[ ] Self-employed [ ] Student

If employed, who is your employer? _____ What is your position: _____

How would you describe your job satisfaction: [ ] Poor [ ] Fair [ ] Good [ ] Great

How would you describe your job performance: [ ] Poor [ ] Fair [ ] Good [ ] Great

What type of employment or training have you had previous to your current occupation? _____

_____

Marital History

Which best describes your marital status? [ ] Married, Date: _____ [ ] Never Married [ ] Widowed, Date: _____
[ ] Separated, Date: _____ [ ] Divorced, Date: _____

If you are married please briefly describe nature of your marital relationship:_____

_____

If you are married, which best describes your marital satisfaction? [ ] Poor [ ] Fair [ ] Good [ ] Great

Please list any previous marriages/significant relationships including current:

First Name	Dates	Nature of Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have children? [ ] Yes [ ] No If yes, complete the following?

First Name	Age	Gender	Nature of Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are there presently any child custody issues involving you or your family? [ ] Yes [ ] No

Substance Abuse History

Are you currently or have you ever struggled with substance abuse? (alcohol, tobacco, marijuana, caffeine, or other)

[ ] Yes [ ] No Additional Information: _____ ____

Have you ever tried to cut down on your drinking or drug? [ ] Yes [ ] No
Are you annoyed when people ask you about your drinking or drug use? [ ] Yes [ ] No
Do you ever feel guilty about your drinking or drug use? [ ] Yes [ ] No
Do you ever take a morning eye-opener of drink or drug? [ ] Yes [ ] No

Legal & Military History

Are you presently, or have you previously served in the military? [ ] Yes [ ] No

Do you currently have any pending criminal charges? [ ] Yes [ ] No

Have you ever been convicted of a crime? [ ] Yes [ ] No: If yes explain: _____

Does you family currently have Division of Family Services Involvement? [ ] Yes [ ] No

If yes please complete the following:

DFS Case Worker's Name: _____ Phone: _____

Additional Information

Summarize your goals for counseling/therapy: _____

_____

_____

Is there any additional information that you believe it is important for your therapist to know in order to provide you with the best care possible? _____

_____

_____

_____

_____ _____

Signature of patient or guardian Date