ECC **EMMAUS CENTER FOR CHRISTIAN COUNSELING**
Personal Intake Form

Please fill out the following information as it applies to you. Please note that the information on this form is confidential. However, you may choose to omit any item and discuss it with me in person.

Identification Data

A. Name _____ Date _____ Age _____ DOB _____

Address _____
street City County Zip code

Home Ph _____ (work) _____ Cell #_____

Marital Status: Single ___ Married __ Divorced Y | N how long ____) Widowed Y | N

How many times married _____ | Separated Y | N (how long _____

Divorced (how long _____) Religious faith_____

Education **circle:** H.S. | Associates | Bachelors | Masters | Doctorate

Occupation_____ | How long _____ Any problems w/work Y/ N

In case of emergency notify: _____

Marriage and Family Information

B. Spouse's Name _____ Age _____ Birth date _____

Home Ph _____ (work) _____ Cell #_____

Marital Status: Single Y | N Engaged Y | N | Married Y | N

How many times married ____ /____ Separated (how long _____)

divorced (how long _____) Religious faith_____

Education **circle:** H.S. | Associates | Bachelors | Masters | Doctorate

Occupation_____ /How long _____ Any problems w/work Y/ N

In case of emergency notify: _____

List name: birth date, sex, relationship of all children, and whether they live at home with you.

Name	Birth date	Age	Sex	Relationship	At Home?

C. Referral Information

How did you learn about our counseling services? _____
If you were referred to me by an individual, please consider sharing his/her name with me: Name_____ Phone_____
May I have your permission to thank this person for the referral? Yes | No
How did this person explain how I might be of help to you? _____
_____

D. Prior Counseling

1. Any prior counseling! Y/N If yes, when? _____ Where? _____
   With whom? _____ Why? _____
2. If engaged or married did you receive pre-marital counseling: Y | N
   With whom? _____ When? _____

***** Are you, or another family member, currently seeing a psychiatrist or another counselor? __ Yes __ No If so, what family member? _____ .
Name of counselor _____ Phone #_____

Address: _____
Street / Apt City County Zip

For what purpose? _____

Person to contact in emergency: name_____ relationship_____
phone_____ address _____
Street City Zip

E. Health Information:

Doctor's name_____ Phone_____ Date last Medical Exam_____
address_____
Street City County Zip
Rate your health: Very good____ Good ___ Average___ Declining___ Other_____

Are you presently taking any medication: __ Yes ___ No If so, what? _____
For what purpose? _____Dosage_____

Any problems with: alcohol___ drugs___ eating disorders ____ sleeping _____
chronic pain __ hearing___ joint pain ____ recent weight changes ___ vision___

Describe any answers checked above: _____

Have you or a family member ever been hospitalized for mental or emotional illness? __ Yes __ No If yes, please explain - dates, place, reason: _____
_____
_____

F. Common problem/symptom checklist. **(Only check items that apply)**

Only Fill in items that apply: **1 = mild, 2 = moderate, 3 = severe.**

___ marriage	___ divorce/separation	___ alcohol/drugs
___ God/faith	___ premarital	___ child custody
___ other addictions	___ church ministry	___ singleness
___ disabled	___ grief/loss	___ past hurts
___ sexual issues	___ work/career	___ depression
___ codependency	___ family	___ school/learning
___ fear/anxiety	___ intimacy	___ children
___ money/budgeting	___ anger control	___ communication
___ parents	___ aging/dependency	___ loneliness
___ self-esteem	___ in-laws	___ weight control
___ mood swings	___ stress management	___ concentrating
___ bad temper	___ bullying	___ nightmares
___ sleep apnea	___ sleep problems	___ panic
___ guilt/shame	___ hearing voices	___ repetitive thoughts
___ confused in my religious beliefs	___ legal problems	___ excessive worry
	___ hurting oneself	___ thoughts of death
___ bitterness	___ jealousy	___ crying spells

Other (specify): _____

G. Crisis Information: Any current suicidal thoughts, feelings, or actions?

Yes| No If yes explain: _____

_____

Any current homicidal or assaultive thoughts of feelings or anger-control problems: Yes | No If yes, explain: _____

Any past problems, hospitalizations? _____

Behavioral Problems? Yes |No If yes, describe: _____

_____

Any current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)? Yes | No If yes, describe _____

_____

Have you ever been arrested: Y / N. If yes, explain: _____

_____

Have you ever been on court probation? Y / N

Are you currently on probation? Y / N If yes, Explain _____

H. Religious Background (Please answer all questions)

What church do you currently attend? _____ Active Member: Y|N

Denomination: _____ Pastor's Name: _____ Ph #_____

Church address_____
Street City County Zip

Have you been saved? Y / N Date:_____ Baptized? Y / N Date_____

Church attendance per month: 1 2 3 4 5 6 7+ Attend Sunday school Y / N

Do you pray daily? Y / N Read the Bible daily? Y / N/

Study Scripture and conduct devotions daily? Y / N Favorite verse: _____

Do you look to the Bible for help with personal problems? Y / N

Do you pray with your spouse daily / weekly / monthly?

Do you pray before making personal decisions in your daily walk-in life? Y / N

If no, why? _____

_____

Do you believe that there is only one God and the Trinity? Y / N

Do you know what the "Exchange Life" means? Y / N

Do you believe God made man with a body, soul and spirit? Y / N If No, why?

_____

Explain any recent changes in your spiritual life:

_____

_____

I. Chief Concerns (Main Problem)

1. State the nature of the problem that brings you here in your own words:

_____

_____

_____

2. What have you done about it? **(Please fill this out)**

_____

_____

3. What do you seek from the counselor?

_____

_____

4. What **circumstances** led to your coming here at this point in time?

_____

_____

5. Describe your spouse's personality in a few words (loving, selfish, etc).

_____

_____

6. Describe yourself, what kind of person are you? _____

_____

7. Is there any other information that you think we should know?

_____

_____

J. Veterans or Public Safety **(Circle one): Yes | No**

> (If you answered yes please fill out this section if you served in any of the below branches of service)

1. **What branch of military service**: Never Served / Army/Navy/Air Force/Marines/Coast Guard National Guard / Reserves: Active / Inactive / Retired / Medically Retired

Are you a combat veteran? Y / N **Do you have a disability** Y | N If yes, Describe:

_____

Have you ever been diagnosed with: PTSD / TBI injury? Y / N_____ Explain:

_____

_____

Public Safety: Fire Dept - Police - Forest Service- Other: _____

Status: Active- Inactive-Volunteer. Do you have any of the above issues? Y/N

If so, Explain: _____

_____

THANK YOU for taking the time to fill out this information sheet. Your counselor will review this with you in the first session and use it to best assist you in your counseling work. We will maintain your strict confidence regarding this information, subject to the exceptions noted in your service contract. Be sure you review and sign the elements of agreement detailed in your service contract.