

PASTORAL COUNSELOR'S INTAKE FORM

Date _____

Your Name _____ Date of Birth _____ Age _____

Referred by _____

Marital Status: Single Married Separated Divorced Widowed Other _____ > Years of current status _____

Your occupation _____ > Years to date _____

Children's names & ages: M or F _____ Age _____ M or F _____ Age _____
[M=male F=female]
M or F _____ Age _____ M or F _____ Age _____

Years formal education completed: H. S. Diploma? Y N College? 1 2 3 4 5 : Degree _____

College Major _____ Graduate School? 1 2 3 4 + : Master's _____ Doctorate _____

Partner's name _____ Date of Birth _____ Age _____

Partner's occupation _____ > Years to date _____

Children's names & ages: M or F _____ Age _____ M or F _____ Age _____
[M=male F=female]
M or F _____ Age _____ M or F _____ Age _____

Years education completed: H. S. Diploma? Y N College? 1 2 3 4 5 : Degree _____

College Major _____ Graduate School? 1 2 3 4 + : Master's _____ Doctorate _____

Your current religious/congregational relationship: _____

Your partner's religious/congregational relationship: _____

Your pastor's name _____ Your partner's pastor's name _____

Family of Origin? Mother living? Y N 1st Name & Location _____

Father living? Y N 1st Name & Location _____

[In birth order:]

Brothers/Sisters Names & Ages: _____

Birth order among brothers & sisters: 1st 2nd 3rd 4th 5th 6th 7th 8th # Half brothers/sisters _____

Name of your personal physician _____ Group? _____

Identify who is aware of your need for seeking help: [circle] Pastor Family members Close friends
Children Physician Supervisor Attorney Others: _____

Need for Help:

Please identify your need for seeking help at this time: _____

Please identify what motivates you at this time to seek help NOW rather than seeking it 3-6 months ago or waiting for another 3-6 months?

Please identify the larger context for your life in which the presenting struggles presently exist. First, identify your assessment of your present life, using the codes below for each of the presented major life areas, and then second, what specific changes you perceive are needed.

- DY = Definitely "Yes!"
- SD = Strongly Desired!
- IW = Improvement Welcomed
- OK = OK & acceptable at this time
- Tops = "Super! Could not be better!"

Codes	Major Life Areas	Specific Changes Needed:
Tops OK IW SD DY	Primary relationship:	
Tops OK IW SD DY	Parenting/Children:	
Tops OK IW SD DY	Family of Origin relationships:	
Tops OK IW SD DY	Extended family relationships:	
Tops OK IW SD DY	Coping with emotions:	
Tops OK IW SD DY	Communication with those special to me:	
Tops OK IW SD DY	Social life:	
Tops OK IW SD DY	Sexual relations:	
Tops OK IW SD DY	Spiritual well-being:	
Tops OK IW SD DY	Mental well-being:	
Tops OK IW SD DY	Physical well-being:	
Tops OK IW SD DY	Finances/Money:	
Tops OK IW SD DY	Job/Work/Career:	
Tops OK IW SD DY	Hobbies/Personal interests:	

Regarding your presenting struggles [and especially those major life areas marked with "DY" and "SD"], **identify your expectations for counseling and therapy:** [Please mark only one!]

- I desire to primarily have the **symptoms** of my presenting problems addressed, disregarding their causes, and have the symptoms greatly diminished or eliminated.
- I desire to have the **causes** of my presenting problems addressed, identified, and treated in counseling and therapy, trusting that appropriate treatment will greatly diminish or eliminate the symptoms.

Physical Health Concerns:

Primary Attending Physician _____ Date of last visit _____

Psychiatrist/Medical Specialist _____ Date of last visit _____

Known major medical struggles [acute & chronic – recent surgeries, hospitalizations, illnesses, injuries, etc.] _____

[If you take multiple medications, a listing of these is invited, listing: (a) drug name, (b) need addressed, (c) dosage, (d) frequency.]

Known allergies and/or negative reactions to medications: None _____

Mental Health History:

Have you ever received treatment for mental or emotional needs professionally? Yes No

If Yes, briefly summarize: _____

Any previous hospitalizations for emotional/mental needs? Yes No If Yes, dates:

Past use of psychotropic medications for emotional/mental needs? Yes No Identify:

Current use of psychotropic medications for emotional/mental needs? Yes No Identify:

Major Losses in Life History:

On the back of this page, please **identify the major losses in life** that you have experienced within the past 5-6 years, or longer if any are still troubling you. Such losses would include: deaths of close family members, friends or pets, separation, divorce, job, change of city, change of residence, friends moved, parent/child relationships, accidents, health functioning, etc.

Thanks for completing this Intake Form !!!