

**PATHWAYS CHRISTIAN COUNSELING CENTER
FIRST BAPTIST DALLAS**

INTAKE FORM

Date _____

Name _____ Birth Date _____

Home Phone _____ Daytime _____ Email _____

Address _____ City/State _____ Zip _____

Occupation _____ Sex _____ Marital Status _____

If married, how long? _____ Spouse's Name _____

Children (if single, list parents, brothers, sisters)

_____	Age _____	Sex _____
_____	Age _____	Sex _____
_____	Age _____	Sex _____

Presenting Problem: (Please circle all that apply)

Marital issues Health issues Job issues Financial issues
Parent/child issues Issues in past (guilt, family of origin, abuse, etc.)
Other _____

Symptoms: (Please circle all that apply)

Change in sleep patterns Change in appetite Hopeless thinking
Decreased motivation Less energy Suicidal feelings/thoughts

Suicidal/Homicidal Ideation: (thoughts)

Have you ever attempted to commit suicide or homicide? ___yes ___no

If yes, how? _____

Is there a history of suicide in your nuclear or extended family ___yes ___no

Are you presently having thoughts of harming yourself or others? ___yes ___no

What recent event has prompted you to seek counseling?

Describe any additional problems you are experiencing and when they developed.

Please circle any losses you have experienced in the past 2 years:

Death of family member Health Job Home/lifestyle

Religious issues: Please briefly describe your relationship with God.

Past Psychiatric History

List previous counselor/psychiatrist: _____

Place _____ Length: ___ 1-2 ___ Several ___ Year (s)

Medical Information

How would you describe your current health? ___ Excellent ___ Good ___ Fair ___ Poor

List any medications you are currently taking: _____

Has it been more than one year since your last physical or blood test? ___ yes ___ no

List any previous health problems: _____

Have you ever abused substances? (alcohol, caffeine, tobacco, drugs) ___ yes ___ no

Describe your usage of any of the following over the past year: Alcohol _____

Caffeine _____ Tobacco _____ Drugs (Rx or other) _____

Nutrition/Sleep Patterns

Have your eating habits changed recently? ___ yes ___ no If yes, how? _____

Has your weight fluctuated +/- 10lbs. over the past year? ___ yes ___ no

Do you ever self-induce vomiting? ___ yes ___ no Binge/eat out of control? ___ yes ___ no

Have your sleep patterns changed recently? ___ yes ___ no If yes, how? _____

Legal History

Have you been convicted of a felony? ___ yes ___ no Of other charges? ___ yes ___ no

If yes, please describe _____

Support System

Please circle all whom you consider to be a support for you (i.e. with whom would you speak concerning personal problems)

Parent Sibling Other relative Good friend Church leader Pastor Doctor

Neighbor Bible study member Stephen's Minister Teacher Boss/Work Assoc.

Work/Adjustment History

How long have you been in your current occupation? _____

Have you had difficulty with employment currently/in recent past? ___ yes ___ no

Current Living Arrangement

With whom do you live? _____

Is this a satisfactory living arrangement? ___ yes ___ no If no, please explain.

Miscellaneous: Is there anything else you believe is important for us to know about you that would help this counseling experience be more effective? _____