WATER'S EDGE
CHRISTIAN COUNSELING, PLLC

Date: _____

Adult Intake Form

About You

Name: _____

DOB: _____ Age: _____ Gender: M / F / O Race/Ethnicity: _____

Address: _____ City: _____ State: _____ Zip: _____

Contact Information

Home _____ May we leave a message? Yes No

Work _____ May we leave a message? Yes No

Mobile _____ May we leave a message? Yes No

May we send text messages? Yes No

Email: _____ May we email reminders? Yes No

(This is the main form of communication through therapy notes)

Your Occupation: _____ Current Employer: _____

How Long: _____

Briefly describe your spiritual belief system: _____

If you attend worship, where do you go? _____

How often do you attend? _____

About Your Health

Please rate your health: Very Good Good Average Declining Special Needs

Are you currently being treated for any medical conditions? _____

List any medications, dosages, and for what reason you take them:

_____

Please rate your sleep pattern: Get a full night's rest ☐ Can't fall asleep ☐ Interrupted Sleep ☐ Other ☐

Have you ever had psychotherapy or counseling before? ☐ Yes ☐ No If yes, please complete:

Provider: _____ When: _____ Reason: _____ Diagnosis: _____

Provider: _____ When: _____ Reason: _____ Diagnosis: _____

Have you ever attempted suicide? ☐ Yes ☐ No If yes, how old? _____

Are you currently having suicidal thoughts? ☐ Yes ☐ No

Are you using:

Caffeine: ☐ Yes ☐ No How much: _____ How Often: _____

Alcohol: ☐ Yes ☐ No How much: _____ How Often: _____

Cigarettes/Tobacco: ☐ Yes ☐ No How much: _____ How Often: _____

Recreational Drugs: ☐ Yes ☐ No How much: _____ How Often: _____

Other Drugs: ☐ Yes ☐ No How much: _____ How Often: _____

Please identify any conditions or issues you have experienced. Please indicate if it was past, present, or both:

Past	Pres.	Condition	Past	Pres.	Condition	Past	Pres.	Condition
○	○	Depression	○	○	Fear	○	○	Religious Abuse
○	○	Stress	○	○	Suicidal Behaviors	○	○	Ritual Abuse
○	○	High Blood Pressure	○	○	Sexual Issues	○	○	Cutting
○	○	Anxiety	○	○	Physical Abuse	○	○	Anorexia/Bulimia
○	○	Bipolar	○	○	Mental Abuse	○	○	Attention Deficit
○	○	Mood Swings	○	○	Emotional Abuse	○	○	Hyper Activity
○	○	Anger	○	○	Verbal Abuse	○	○	Difficulty Concentrating
○	○	Compulsivity	○	○	Headaches	○	○	Diabetes
○	○	Nightmares	○	○	Chronic Fatigue	○	○	Asthma/Allergies
○	○	Flashbacks	○	○	Sleep Disorder	○	○	Apathy
○	○	Grief/Loss/Sadness	○	○	Overeating	○	○	Obsessive Thoughts
○	○	Guilt/Shame	○	○	Loneliness	○	○	Abandonment
○	○	Hopelessness	○	○	Betrayal	○	○	Low Self-Esteem

Please identify any parents or siblings currently experiencing, or have been treated for any of the conditions/issues listed above: _____

About Your Parents and Family History

Were you raised by anyone other than your biological parents? Yes ☐ No ☐ If yes, who raised you? _____

If yes, did you know or have a relationship with you biological parents? Yes ☐ No ☐

What best described your household while growing up:

☐ One Mother & One Father ☐ Single Parent ☐ Blended Family ☐ Other: _____

How many siblings did you have (note birth order)? _____

While growing up did your parents divorce? ☐ Yes ☐ No Did either remarry? _____

About Your Significant Other (SO)

Current Relationship Status Single Committed Relationship Engaged Married Divorced Widow

SO's Name: _____ DOB: _____ Age: _____ Gender: M / F Race/Ethnicity: _____

SO's Occupation: _____ Employer: _____ How long? _____

Briefly describe your SO's spiritual belief system: _____

If they attend worship, where do they go and how often? _____

How long did you know your SO before your relationship? _____

Length of: Dating: _____ Engagement: _____ Marriage: _____

Please rate your level of commitment to your relationship:

[-10 (divorcing/breaking up) to +10 (looking forward to the future with them)]

-10 -9 -8 -7 -6 -5 -4 -3 -2 -1 0 +1 +2 +3 +4 +5 +6 +7 +8 +9 +10

Have you or your SO ever cheated/had an affair? Yes No

Have you ever been separated? Yes No When? _____ How long? _____

Has either of you ever filed for divorce? Yes No If yes, when? _____ Was it granted? _____

Previous Committed Relationships: How many? _____ Reason relationship(s) ended: _____

_____

If widowed or divorced, how long: _____

About Children

**Check first column if child is by a previous relationship*

PR	Child's Name	Gender	Age	Does child live with you?	Relationship of this child to you
		M F		Y N	Biological Other
		M F		Y N	Biological Other
		M F		Y N	Biological Other
		M F		Y N	Biological Other

Are you currently pregnant? Yes No Due date: _____

Have you or your SO ever been involved with abortion? Yes No If yes, how many? _____

Have you ever experienced miscarriage? Yes No If yes, how many times? _____

Have you ever experienced the loss of a child? Yes No If yes, how old was the child? _____

Current Concerns

Please describe your reason for seeking counseling today: _____

_____

With whom else have you discussed this issue? _____

What steps have you already taken to resolve the issue? _____

_____

What do you hope to accomplish through counseling? _____

What do *you* expect to do in counseling? _____

Does your spouse/family know you are seeking counseling? Yes No Are they supportive? Yes No

Is there any information we should know that we didn't think to ask already? _____

_____

Referral Information

Who referred you? Client Family Friend Church Internet Doctor Another Licensed Counselor

About Us

Fees: Water's Edge Christian Counseling, PLLC does not accept insurance at this time. Sessions are a flat rate of $135 per 50 minute session that is collected at the time of service.

Consent to Counseling

By signing the Consent to Counseling:

I, voluntarily, agree to receive counseling assessment, care, treatment, and/or services from Water's Edge Christian Counseling, PLLC, and authorize the undersigned counselor to provide such care, treatment, and/or services as are considered necessary and advisable.

I agree to participate in the planning of this care, treatment, and/or services and acknowledge that I may stop such care, treatment, or services at any time.

I acknowledge receiving a copy of the *Client Information* and have read and agree to all the terms and information contained therein. Opportunity has been given to ask questions and seek clarification of anything unclear.

_____ _____

Client/Legal Representative Date

_____ _____

Counselor Date