Whole Hope Christian Counseling, LLC

Individual, Couple, and Family Counseling
Mediation and Conciliation

Intake Form

Welcome to Whole Hope Christian Counseling, LLC *(EIN: 81-4201353).* Please complete the intake form below and submit prior to your first session to help aid in the process of your care.

Please note: information provided on this form is protected as confidential information.

Personal Information

Name:_____Date:_____

Parent/Legal Guardian (if under 18):_____

Address:

_____Ho

me Phone: _____ May we leave a message? □ Yes □ No

Cell/Work/Other Phone: _____May we leave a message? □ Yes □ No

Email: _____May we leave a message? □ Yes □ No

DOB: _____ Age: ____ Gender: _____

Marital Status: □ Never Married □ Married □ Separated □ Divorced □ Widowed □ Other

Referred By (if any); _____

History Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes, previous therapist/practitioner:

_____

_____

Are you currently taking any prescription medication? □ Yes □ No If yes, please list:

_____

_____Have

you ever been prescribed psychiatric medication? □ Yes □ No If yes, please list and provide dates:

_____

_____

_____

_____

_____

General and Mental Health Information

1. How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:_____

_____

_____

2. How would you rate your current sleeping habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

_____

_____

3. How many times per week do you generally exercise?

_____

What types of exercise do you participate in?_____

4. Please list any difficulties you experience with your appetite or eating problems:

_____

_____

_____

5. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long?

_____

6. Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this?

_____

7. Are you currently experiencing any chronic pain? □ No □ Yes If yes, please describe:

_____

8. Do you drink more than one alcoholic beverage a day? □ No □ Yes

9. How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes If yes, for how long? _____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?

_____

11. What significant life changes or stressful events have you experienced recently?

_____

_____
_____

Family Mental Health History In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.) Please Circle List Family Member

Alcohol/Substance Abuse yes / no _____

Anxiety yes / no _____

Depression yes / no _____

Domestic Violence yes / no _____

Eating Disorders yes / no _____

Obesity yes / no _____

Obsessive Compulsive Behavior yes / no _____

Schizophrenia yes / no _____

Suicide Attempts yes / no _____

Additional Information

1. Are you currently employed? □ No □ Yes If yes, what is your current employment situation?

_____
_____
_____Do you enjoy your work? Is there anything stressful about your current work?

_____
_____
_____

2. Do you consider yourself to be a Christian? □ No □ Yes

Please describe your faith or beliefs and the role they play in your life:

_____
_____
_____
_____
_____

3. What do you consider to be some of your strengths?

_____
_____
_____

4. What do you consider to be some of your weaknesses?

5. What would you like to accomplish out of your time in counseling?

6. Do you have any concerns about Biblical Counseling. If so, what are your concerns?