PATHWAYS CHRISTIAN COUNSELING CENTER
FIRST BAPTIST DALLAS

INTAKE FORM

Date _____

Name _____ Birthdate _____

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?_____

_____