Adult Client Intake Information

The purpose of the following questionnaire is to help your counselor understand some important things about you in order to help you most effectively. Please complete all pages.

Name_____ Date_____
(Last) (First) (Middle)

Address_____

City_____ Zip Code _____ E-mail _____

Phone (H)_____ (W)_____ Other_____

Emergency Contact_____
(Name) (Address) (Phone)

Birth Date_____ Age_____ Gender _____M _____F

I am: Single_____ Divorced_____ Engaged_____

Separated_____ Widowed_____ Other_____

Married_____ # Years_____ Name of Spouse_____

Spouse's Age_____ Spouse currently living with you?_____

Previous Marriages (#s and length of each)_____

Please list the names and ages of your children:

Names Ages Indicate where they live

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Occupation_____

Place of Employment_____ Years_____

Any major career changes? _____ If yes, from: _____ to: _____

Education & Degree (if applicable) _____

Name of church you attend (if applicable) _____

Who referred you to Still Waters Ministries?_____

Client Consultation Information (continued)

Family History:

Describe your family's relationship with one another growing up? (ex: how did your parents get along, how did you and your siblings get along?). _____

_____

_____

Discuss your current relationship with your parents. _____

_____

_____

Please list your brothers, sisters, and yourself in birth order starting with the oldest. Give their ages. Be sure to include yourself by indicating "me".

Names Ages

_____ _____

_____ _____

_____ _____

_____ _____

Does someone in your family have a substance abuse problem? _____

_____

Has someone in your family ever received counseling or psychiatric diagnosis? _____

_____

Have you or a family member ever experienced domestic violence? _____

_____

Client History:

My health is: Excellent_____ Good_____ Average_____ Poor_____

Date of Last Medical Exam? _____

Do you take medication?_____ Type or Name? _____

Have you ever received counseling before? Yes_____ No_____

If so, list counselor(s) and dates: _____

Client Consultation Information (continued)

What was helpful? _____

_____

_____

Have you had any major losses or traumatic experiences in your life? _____

_____

What event or crisis led you to seek counseling at this time?

_____

_____

_____

Describe how you hope counseling will help you.

_____

_____

_____

_____

_____