



THE RELATIONSHIP CENTER

Branson • Springfield

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“Biblically Christian, Clinically Proven”

ADULT INTAKE

Confidential

Please Print Clearly

Name: _____ Birthdate: _____ Gender: M / F

Address: _____ Social Security Number: _____

City: _____ State: _____ Zip: _____ Home phone: _____ Cell: _____

E-mail: _____ List the persons with whom you are now living, their ages and their relationship to you:

Calls or e-mail will be discreet, but please indicate any restrictions: _____

Emergency contact person: _____ Relationship to you: _____ Phone(s): _____

Occupation: _____ Education level: _____

Employer: _____ Length of employment: _____ Work phone: _____

Were/are you a member of the armed services? _____ If so, when? _____ What branch? _____

Spouse's name: _____ Birthdate: _____ Social Security Number: _____

Spouse's occupation: _____ Education level: _____

Spouse's employer: _____ Length of employment: _____ Work phone: _____

Referral

How did you find out about us? _____ How did you find our website? _____

Name of referral source: _____ Phone: _____

If applicable, may we have your permission to confidentially contact this person to thank them for the referral? YES NO

Physical Health

Current health status (circle one): Excellent Good Fair Poor Date of last physical exam: _____

Clinic or physician's name: _____ Phone: _____

What serious illnesses have you had and when? _____

Hospitalizations (reason/diagnosis/dates): _____

Describe any current physical problems/illnesses: _____

List any medications you are now taking and their purpose (including nonprescription medications like sleeping pills, diet pills, etc.):

MEDICATION	PURPOSE	DOSAGE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Prescribed by: _____ If applicable, may we contact your physician in order to coordinate care? YES NO

List any current or past history of alcohol and/or drug misuse for you and/or any family member: _____

List any current or past history of any nervous and/or mental disorder for you and/or any family member: _____

List any current or past history of legal difficulty or trouble with the law: _____

Problem Information

Briefly describe what brings you into counseling: _____

Briefly describe the history and development of your concern from onset to present: _____

Why are you coming for counseling now instead of a few months ago or a few months from now? _____

What are your goals for counseling—what do you wish to accomplish? _____

What specific concerns or anxieties do you have about counseling? _____

Rate how strongly you want to change your problem: (do not want to change) 1 2 3 4 5 6 7 8 9 10 (desperately desire change)

Have you been to counseling before? _____ When? _____ With whom? _____

If so, briefly describe your experience: _____

Current stressors (please describe how the following areas are stressful for you):

Marriage/home: _____

Children/parents: _____

Work/school: _____

Financial: _____

Social: _____

Spiritual: _____

Sexual: _____

Other: _____

Major present stress: _____

Date and place of last vacation: _____

Family Background

Father's name: _____ If deceased, date and cause: _____

Age: _____ Occupation: _____ Education level: _____ Health: _____

Describe his personality, attitude towards and relationship with you, past and present: _____

Mother's name: _____ If deceased, date and cause: _____

Age: _____ Occupation: _____ Education level: _____ Health: _____

Describe her personality, attitude towards and relationship with you, past and present: _____

Parents' marital status: _____ Briefly describe your parents' marriage: _____

How did they handle conflict in their relationship? _____

If divorced, when did it occur and what was your reaction to it? _____

If one or both of your parents remarried, when did it occur and what was your reaction to it? _____

Step-father's name: _____ Age: _____ Occupation: _____

Describe his personality, attitude and relationship with you, past and present: _____

Step-mother's name: _____ Age: _____ Occupation: _____

Describe her personality, attitude and relationship with you, past and present: _____

If you were not brought up by your parents, who raised you? _____

Between what years? _____ Who took care of you as an infant? _____

How were you disciplined as a child and by whom? _____

Siblings (list names, ages, marital status, occupation and place of residence): _____

Give your impression of the home atmosphere in which you grew up, including how people got along: _____

How was love expressed in your parents' home? _____

How was anger expressed in your parents' home? _____

What was their attitude towards sex and was there any teaching about it? _____

Were you or your siblings ever physically and/or sexually abused, assaulted or neglected? _____

Marital History

Marital status: _____ How long did you know your spouse before engagement? _____ Length of engagement: _____

When did your relationship become sexualized? _____ Did you cohabit before marriage? Y / N Length? _____

Date of marriage: _____ List names and ages of children/stepchildren and indicate which (if any) are from a previous relationship: _____

Describe the strengths of your marriage: _____

Describe the conflicts in your marriage: _____

Describe your relationship with your in-laws: _____

Date(s) of previous marriage(s)/divorce(s): _____

Religious/Spiritual Identification

Describe the religious teaching you received growing up and how God was viewed by your family? _____

How important are spiritual concerns to your life? _____

How would you describe your current spiritual life? _____

Denominational affiliation: _____ Average monthly worship attendance: _____

Do you want your therapist to integrate Christian spirituality into your counseling process? YES NO

Symptom Checklist (please check all that apply)

- I am dissatisfied with my life and want a change
- I am dissatisfied with the current state of my family life
- I am dissatisfied in my relationship with my spouse or significant other
- I am dissatisfied with, confused about or have questions regarding the sexual part of my life
- I am dissatisfied with my interpersonal relationships in general
- I am dissatisfied with my body
- In the past few months I have thought about how I could end my life

I have recently experienced:

- moodiness change in sex drive resentment mental confusion or disorientation
- unusual anger or irritability change of appetite stomach trouble decreased energy or motivation
- anxious feelings unusual fatigue bowel disturbances feelings of helplessness
- inability to relax difficulty sleeping racing thoughts feelings of sadness, loss or grief
- loneliness nightmares apathy/hopelessness inferiority feelings

In the last few months in order to try to feel better about my life, I have done the following:

- binge eating ignored my normal responsibilities worked more than usual
- drank alcohol refused to get out of bed or do normal hygiene used pornography or erotic material
- used illegal drugs isolated myself from people acted sexually in an unusual way for me
- misused prescribed drugs constantly surrounded myself with people harmed myself by cutting, burning, etc.

In my lifetime I have experienced:

- the loss of a loved one an abortion abandonment by important people to me
- a traumatic event divorce of my parents exploitation by important people to me
- sexual abuse or assault divorce of my own being unloved by important people to me
- physical abuse or assault the loss of someone by suicide being fired from a job
- mental or verbal abuse an addictive habit something else significant to me _____
- the death of a child living with someone who was/is addicted _____

Is the information you provided on this form true and accurate? _____

Form completed by: _____ Date: _____