FOR CALVARY COUNSELING CENTER USE ONLY

Axis I:_____ (P)
_____(S)
Axis II:_____
Axis III:_____
Axis IV:_____
Axis V:_____

Calvary Counseling Center
9300 Forest Point Circle
Manassas ,VA 20110
(703) 530-9800
Fax: (703) 530-9805

Confidential Individual Intake Form

Contact Information

Name: _____ Date: _____

Sex: **0** Male **0** Female Height: _____ Weight: _____

SS#: _____ Age: _____ DOB: _____

Address: _____
Street Address City State Zip

Phone: _____
Home Business Cell

Emergency Contact Information

Emergency Contact Person: _____
Name Relationship to you

Emergency Contact's Phone: _____
Home Business Cell

Employment Information

Employer: _____ Occupation/Title:_____

Employer Information: _____
Address Phone

Hours per week: _____ Years at job: _____ Highest level of education completed: _____

Education ( ) Some High School ( )Some College ( ) Graduate School
( ) High School Graduate/GED ( ) College Graduate ( ) Degrees Held _____

Cultural/Religious Information

Race: **0** Caucasian **0** African-American **0** Hispanic **0** Native American **0** Asian **0** Other _____

Cultural heritage (i.e., Italian, Scottish, Argentinean): _____
Do you regularly attend a church, synagogue or other religious institution? **0** Yes **0** No Member? **0** Yes **0** No

Name of church/institution: _____

Name of pastor: _____

Relational Information

Marital status: **0** Single **0** Engaged **0** Married **0** Separated **0** Divorced **0** Widowed

If engaged, married, divorced or widowed, how long have you been so? _____

Number of previous marriages for you? _____ For your current spouse? _____

Name of spouse: _____ Spouse's age: _____

Spouse's Occupation: _____

Please provide a brief description of your spouse's characteristics (e.g., angry, controlling, outgoing, supportive):_____
_____

Please list your children, including step, adopted and foster children (use back of sheet if necessary):

Name	Sex	Age/Year of death	Relationship to you	Living with whom?

Family of Origin

Please list your mother, father, brothers, sisters, stepfamily and/or relatives who had a significant effect upon your life (positive or negative).

Name	Sex	Age/Year of death	Relationship to you	Describe him/her

Please identify any of the following you experienced in your family:

0 Physical Abuse **0** Emotional Abuse **0** Sexual Abuse **0** Abortions **0** Gambling
0 Drug/Alcohol Addiction **0** Religious Upbringing **0**Major Losses **0** Multiple Marriages

Please describe the kind of family you grew up in: _____

_____

_____

Counseling History

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the name of the therapists and/or programs (use back of this sheet if necessary):

Name of Therapist/Program	Issues Addressed	Dates in Treatment

Has anyone in your family ever been treated or hospitalized for substance abuse, mental health issues, or psychiatric conditions? **0** Yes **0** No

If yes, please describe: _____

Have any of your family or friends ever attempted or committed suicide? **0** Yes **0** No

If yes, who and when: _____

Medical History

Name and Town of Current Physician: _____

Date and outcome of last physical exam: _____

Please list any conditions, illnesses or surgeries that might be relevant to your reason for seeking counseling:

_____

Please list current medications you are taking even if use is seldom or as needed (use back of sheet if necessary):

Name of Medication	Dosage	Reason for taking medication

Present Issues and Goals

Circle any of the flowing symptoms or problems that you are currently or have recently experienced:

0 Stress	**0** Grief	**0**Verbal abuse	**0**Impulsive behavior	**0** Anxiety
0 Chronic pain	**0** Sexual abuse	**0** Controlling	**0** Sexual problems	**0** Fears
0 Loneliness	**0** Sexual addiction	**0** Obsessive thoughts	**0** Depression	**0** Panic
0 Compulsive behavior	**0** Poor concentration	**0** Shyness	**0** Gender identity	**0** Anger
0 Fatigue	**0** Low self-esteem	**0** Hearing voices	**0** Loss of appetite	**0** Bad dreams
0 Marital problems	**0** Aggression	**0** Racing thoughts	**0** Trouble sleeping	**0** Apathy
0 Relational issues	**0** Eating problems	**0** Physical Abuse	**0** Unwanted memories	**0** Alcohol use
0 Feeling worthless	**0** Emotional Abuse	**0** Loss of control	**0** Pregnancy/Abortion	**0** Work issues
0 Financial issues	**0** Controlled by others	**0** Drug use	**0** Career choices	**0** Loss
0 Indecisiveness	**0** Spiritual apathy	**0** Seeing/Hearing things others don't		

Please describe why you are coming to counseling (issues, problems, symptoms, how long, etc.):

_____

_____

_____

Please circle on the scale below to indicate how distressing your problems are to you.

Very minimal distress Moderate distress Very extreme distress

Are you currently experiencing any suicidal thoughts? **0** Yes **0** No

Have you experienced suicidal thoughts or attempted suicide in the past? **0** Yes **0** No

Are you currently experiencing any violent or homicidal thoughts? **0** Yes **0** No

Please describe any of the following:

_____
_____
_____

Referral Information

How did you find us (referred by doctor, friend, family, internet, EAP or other)? _____

_____