Love-light Christian Counseling, NFP

Patient (Adult) Intake Questionnaire

Patient's Name: _____ Age: _____ D.O.B.: _____ S.S.#.: _____

☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: (_____) _____ E-mail: _____ @ _____

Work Phone #: (_____) _____ Cell Phone #: (_____) _____

Race: _____ Religious Faith: _____ Highest Education Level: _____

Employer: _____ Position: _____ Income Level: _____

Emergency Contact: _____ Emergency Phone #: (_____) _____

Presenting Problem(s): (Check all that apply)

☐ Abuse	☐ Compulsive Behaviors	☐ Marriage/Relational	☐ Self-esteem/Identity
☐ Abusive of Others	☐ Depression	☐ Medical	☐ Separation/Divorce
☐ Abusive to Self	☐ Domestic Violence	☐ Moodiness	☐ Sexual/Lust
☐ Alcohol/Drugs	☐ Eating	☐ Obsessive Thoughts	☐ Sleep
☐ Anger/Temper	☐ Family	☐ Parent-Child/Parent-Teen	☐ Spiritual Struggles
☐ Anxiety/Worry	☐ Finances/Money	☐ Peer Conflict	☐ Stress
☐ Attention-Deficit	☐ Grief/Loss	☐ Physical Disability	☐ Suicidal
☐ Blended-Family	☐ Home Behavior	☐ Poor Memory	☐ Suspensions
☐ Boundaries	☐ Infidelity/Unfaithfulness	☐ Post-traumatic Stress	☐ Thought Disorders
☐ Child Discipline	☐ Learning Disabilities	☐ Property Destruction	☐ Trauma/Crisis
☐ Childhood Abuse	☐ Legal/Court	☐ School Behavior	☐ Truancy
☐ Communication	☐ Loneliness	☐ School Work/Grades	☐ Work

Describe Presenting Problem(s): _____

_____

_____

How long have you had this problem? _____ How have you tried to solve problem? _____

Any previous counseling? ☐ No ☐ Yes When? _____ How Long? _____ With Whom? _____

Current Medications: When? _____ How Long? _____ With Whom? _____

Medication: _____ Dosage: _____ For?: _____ Prescribed By: _____

Medication: _____ Dosage: _____ For?: _____ Prescribed By: _____

Medication: _____ Dosage: _____ For?: _____ Prescribed By: _____

Medication: _____ Dosage: _____ For?: _____ Prescribed By: _____

Marital Status: ☐ Single, Never Married ☐ Living w/ Someone ☐ Dating / Engaged ☐ Married ☐ Remarried
☐ Single, Divorced ☐ Separated ☐ Divorced ☐ Widowed/Widower ☐ _____

Spouse/Significant Other: (if applicable)

Name: _____ Age: _____ D.O.B.: _____ S.S.#: _____

☐ Male ☐ Female

Work Phone #: (_____) _____ Cell Phone #: (_____) _____

Race: _____ Religious Faith: _____ Highest Education Level: _____

Employer: _____ Position: _____ Income Level: _____

Years Together? _____ Years Married? _____ Ever Separated? _____ If so, When? _____ For How Long? _____

Relationship with Spouse/S.O.: ☐ Excellent ☐ Close ☐ Fair ☐ Struggling ☐ Poor ☐ Distant ☐ Conflictual

This is Patient's?: ☐ 1st Marriage/Relationship ☐ 2nd Marriage/Relationship ☐ 3rd or more Marriage/Relationship

Previous Relationship ended in: ☐ Separation ☐ Divorce ☐ Death Years Together? _____ Dates: _____

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Previous Relationship ended in: ☐ Separation ☐ Divorce ☐ Death Years Together? _____ Dates: _____

Previous Relationship ended in: ☐ Separation ☐ Divorce ☐ Death Years Together? _____ Dates: _____

Patient's Characteristics: (Check all that apply)

☐ Abusive / Angry
☐ Active/Athletic
☐ Aloof
☐ Always at Home
☐ Always on the Go
☐ Angry
☐ Artistic/Creative
☐ Bad Attitude
☐ Busy All the Time
☐ Chaotic
☐ Closed
☐ Compulsive
☐ Consistent
☐ Controlling
☐ Couch-potato
☐ Critical
☐ Deceptive
☐ Defiant
☐ Detail-oriented
☐ Distracted
☐ Dishonest
☐ Disorganized
☐ Distant
☐ Easy-going
☐ Enmeshed
☐ Extraverted
☐ Fast-paced
☐ Fights/Argues
☐ Flexible
☐ Follower
☐ Hyperactive
☐ Intelligent
☐ Introverted
☐ Inattentive
☐ Isolative
☐ Leader
☐ Lenient
☐ Loving
☐ Lying
☐ Manipulative
☐ Neglectful
☐ Never home
☐ Nurturing
☐ Obsessive
☐ Open
☐ Organized
☐ Over/Under weight
☐ Poor Health
☐ Punitive
☐ Quiet
☐ Relaxed
☐ Rigid
☐ Shut-down
☐ Shy
☐ Sneaky/Deceptive
☐ Social-butterfly
☐ Spontaneous
☐ Stable
☐ Strict
☐ Structured
☐ Stubborn
☐ Supportive
☐ Talkative
☐ Tense
☐ Too Busy
☐ Trusting
☐ Trustworthy
☐ Truthful
☐ Unfocused
☐ Unstructured
☐ Validating
☐ Violent
☐ Warm
☐ Wary

Spouse's/Significant Other's Characteristics: (Check all that apply)

☐ Abusive / Angry
☐ Active/Athletic
☐ Aloof
☐ Always at Home
☐ Always on the Go
☐ Angry
☐ Artistic/Creative
☐ Bad Attitude
☐ Busy All the Time
☐ Chaotic
☐ Closed
☐ Compulsive
☐ Consistent
☐ Controlling
☐ Couch-potato
☐ Critical
☐ Deceptive
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☐ Intelligent
☐ Introverted
☐ Inattentive
☐ Isolative
☐ Leader
☐ Lenient
☐ Loving
☐ Lying
☐ Manipulative
☐ Neglectful
☐ Never home
☐ Nurturing
☐ Obsessive
☐ Open
☐ Organized
☐ Over/Under weight
☐ Poor Health
☐ Punitive
☐ Quiet
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☐ Rigid
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☐ Shy
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☐ Social-butterfly
☐ Spontaneous
☐ Stable
☐ Strict
☐ Structured
☐ Stubborn
☐ Supportive
☐ Talkative
☐ Tense
☐ Too Busy
☐ Trusting
☐ Trustworthy
☐ Truthful
☐ Unfocused
☐ Unstructured
☐ Validating
☐ Violent
☐ Warm
☐ Wary

Current Marriage/Family/Relational Characteristics: (Take into consideration all who currently live in home). (Check all that apply)

☐ Abusive / Angry
☐ Aloof
☐ Always at home
☐ Always on the go
☐ Busy all the time
☐ Chaotic
☐ Close
☐ Consistent
☐ Controlling
☐ Couch-potatoes
☐ Critical
☐ Detail-oriented
☐ Disorganized
☐ Distant
☐ Easy-going
☐ Enmeshed
☐ Fast-paced
☐ Fighting/Arguing
☐ Flexible
☐ Inconsistent
☐ Involved
☐ Lenient
☐ Loving
☐ Never home
☐ Nurturing
☐ Organized
☐ Punitive
☐ Relaxed
☐ Rigid
☐ Social-butterflies
☐ Spontaneous
☐ Stable
☐ Strict
☐ Structured
☐ Supportive
☐ Take time to relax
☐ Tense
☐ Too many things going on
☐ Trusting
☐ Trustworthy
☐ Truthful
☐ Unstructured
☐ Validating
☐ Warm
☐ Wary
☐ Recent Birth
☐ Recent Death
☐ Recent Divorce
☐ Recent Financial Change
☐ Recent Job Change/Loss
☐ Recent Legal Problems
☐ Recent Live-in
☐ Recent Major Illness
☐ Recent Marriage
☐ Recent Move
☐ Recent School Change
☐ Recent Separation

Children:

Name: ______________________________ Age: ________ Lives with Patient? ☐ Full-time ☐ Part-time ☐ No
☐ Male ☐ Female ☐ Biological-Child ☐ Step-Child ☐ Adoptive-Child ☐ Deceased

Name: ______________________________ Age: ________ Lives with Patient? ☐ Full-time ☐ Part-time ☐ No
☐ Male ☐ Female ☐ Biological-Child ☐ Step-Child ☐ Adoptive-Child ☐ Deceased

Name: ______________________________ Age: ________ Lives with Patient? ☐ Full-time ☐ Part-time ☐ No
☐ Male ☐ Female ☐ Biological-Child ☐ Step-Child ☐ Adoptive-Child ☐ Deceased

Name: ______________________________ Age: ________ Lives with Patient? ☐ Full-time ☐ Part-time ☐ No
☐ Male ☐ Female ☐ Biological-Child ☐ Step-Child ☐ Adoptive-Child ☐ Deceased

Others Living in Home: (use for additional children if necessary)

Name: ______________________ Age: ________ Lives with Patient? ☐ Yes ☐ No
☐ Male ☐ Female ☐ Parent ☐ Grandparent ☐ Relative ☐ Friend ☐ Other: ____________

Name: ______________________ Age: ________ Lives with Patient? ☐ Yes ☐ No
☐ Male ☐ Female ☐ Parent ☐ Grandparent ☐ Relative ☐ Friend ☐ Other: ____________

Name: ______________________ Age: ________ Lives with Patient? ☐ Yes ☐ No
☐ Male ☐ Female ☐ Parent ☐ Grandparent ☐ Relative ☐ Friend ☐ Other: ____________

Patient's Parents:

Father/Stepfather's Name: ____________________ Age: ________ City Lives in?: ____________________ ☐ Deceased
Relationship to Patient's Mother: ☐ Never Together ☐ Live-in ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Current Relationship: ☐ Still with Patient's Mother ☐ Single ☐ Remarried ☐ Living with Someone ☐ Other: __________

Mother/Stepmother's Name: ____________________ Age: ________ City Lives in?: ____________________ ☐ Deceased
Relationship to Patient's Father: ☐ Never Together ☐ Live-in ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Current Relationship: ☐ Still with Patient's Father ☐ Single ☐ Remarried ☐ Living with Someone ☐ Other: __________

Parent's Relationship is/was: ☐ Excellent ☐ Close ☐ Fair ☐ Struggling ☐ Poor ☐ Distant ☐ Conflictual ☐ Abusive

Patient's age when: Parent's Married_______ Parent's Separated_______ Parent's Divorced______ Patient was Adopted______

Patient's age when: Mother Remarried________ Father Remarried________ Mother Died _______ Father Died_______

Patient's Siblings:
Patient's Birth Order:________ of ________ Total # of Siblings: _________ # of Brothers:__________ # of Sisters:____________

Name: ______________________ Age: ________ City Lives in?: ____________________
☐ Male ☐ Female ☐ Full-Sibling ☐ Half-Sibling ☐ Step-Sibling ☐ Adoptive ☐ Deceased

Name: ______________________ Age: ________ City Lives in?: ____________________
☐ Male ☐ Female ☐ Full-Sibling ☐ Half-Sibling ☐ Step-Sibling ☐ Adoptive ☐ Deceased

Name: ______________________ Age: ________ City Lives in?: ____________________
☐ Male ☐ Female ☐ Full-Sibling ☐ Half-Sibling ☐ Step-Sibling ☐ Adoptive ☐ Deceased

Name: ______________________ Age: ________ City Lives in?: ____________________
☐ Male ☐ Female ☐ Full-Sibling ☐ Half-Sibling ☐ Step-Sibling ☐ Adoptive ☐ Deceased

Name: ______________________ Age: ________ City Lives in?: ____________________
☐ Male ☐ Female ☐ Full-Sibling ☐ Half-Sibling ☐ Step-Sibling ☐ Adoptive ☐ Deceased

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Interaction of Family (While Growing-up):	Never	Seldom	Sometimes	Usually	Always
Argued/Yelled/Fought/Name Calling	☐	☐	☐	☐	☐
Ate meals together as a family	☐	☐	☐	☐	☐
Did things together as a family	☐	☐	☐	☐	☐
Enjoyed spending time together	☐	☐	☐	☐	☐
Everyone did their own thing	☐	☐	☐	☐	☐
Helped and supported each other	☐	☐	☐	☐	☐
Openly showed affection to each other	☐	☐	☐	☐	☐
Played games together as a family	☐	☐	☐	☐	☐
Shared feelings with each other	☐	☐	☐	☐	☐
Shared household chores	☐	☐	☐	☐	☐
Spent time together	☐	☐	☐	☐	☐
Watched TV together as a family	☐	☐	☐	☐	☐
Went out-to-eat together as a family	☐	☐	☐	☐	☐
Went places together as a family	☐	☐	☐	☐	☐
Were open and honest with each other	☐	☐	☐	☐	☐
Were too busy	☐	☐	☐	☐	☐

Other Relevant Information regarding Family (while growing-up or now):

____

____

____

____

Patient's Abuse & Substance History (Check all that apply)

Patient has been Abused? ☐ Emotionally ☐ Mentally ☐ Physically ☐ Sexually ☐ Verbal ☐ Rape ☐ Never/None

Patient was Abused by? ☐ Parent ☐ Relative ☐ Acquaintance ☐ Date ☐ Spouse ☐ Date ☐ Other_____

Frequency of Abuse? ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ One-time Only ☐ Situational_____

☐ As a Child ☐ As a Teen ☐ As a Young Adult ☐ Currently ☐ Ritually ☐ Situational_____

Patient Substances Tried? ☐ Alcohol ☐ Tobacco ☐ Marijuana ☐ Amphetamines ☐ Hallucinogenic ☐ Other_____

Frequency of Usage? ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ One-time Only ☐ Situational_____

☐ As a Child ☐ As a Teen ☐ As a Young Adult ☐ Currently ☐ Socially ☐ Situational_____

Patient Current Usage? ☐ Alcohol ☐ Tobacco ☐ Marijuana ☐ Amphetamines ☐ Hallucinogenic ☐ Other_____

Frequency of Usage? ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ One-time Only ☐ Situational_____

Please describe in more detail anything identified above regarding abuse or substance usage. _____

Did anyone in family have a drug or alcohol problem? ☐ No ☐ Yes Who?/What?_____

Does Patient or anyone in family suffer from psychological problems? ☐ No ☐ Yes Who?/What?_____

Describe any significant losses, deaths, or traumas in Patient's life. _____

Describe any other relevant medical/ psychological information._____

Patient's Medical History: (Check all that apply; Past and/or Present)

☐ Abortion	☐ Eating Disorder	☐ Hospitalized	☐ Recent Weight Changes
☐ Allergies	☐ Encephalitis	☐ Joint Problems	☐ Rectal Bleeding
☐ Anorexia/Bulimia	☐ Extreme Tiredness	☐ Liver Problems	☐ Seizures
☐ Asthma	☐ Extreme Weakness	☐ Loss of Consciousness	☐ Severe Headaches
☐ Back Problems	☐ Eye Problems/Poor Vision	☐ Memory Problems	☐ Sexually Transmitted Disease (STD)
☐ Blood Disease	☐ Frequent Headaches	☐ Meningitis	☐ Skin Problems
☐ Bowel Problems	☐ Gallbladder Problems	☐ Miscarriage	☐ Sleep Problems
☐ Cancer	☐ Head Injury	☐ Mouth/Throat Problems	☐ Stillbirth
☐ Chest Pain	☐ Heart Problems/Disease	☐ Neck Stiffness/Pain	☐ Stomach Trouble
☐ Circulatory Problems	☐ Hemorrhoids	☐ Nose/Sinus Problems	☐ Thyroid Disease
☐ Convulsions	☐ Hepatitis (Type_____)	☐ Overweight	☐ Underweight
☐ Diabetes	☐ High Blood Pressure	☐ Premenstrual Syndrome (PMS)	
☐ Ear Problems/Poor Hearing	☐ HIV/AIDS		

Explanation of anything checked above: _____

List any hospitalizations, operations, and/or major injuries: _____

Please describe how we can help you: _____

Patient's Talents and Interests:

List things Patient is interested in, likes to do, and/or is good at or talented in._____

List the positive qualities or strengths of Patient._____

List the negative qualities, weakness, or things needing improvement in Patient._____

Patient's Spiritual History:

Patient's Faith Heritage: ☐ Christian (Practicing) ☐ Christian (Non-practicing) ☐ Atheist ☐ Agnostic ☐ Other _____

Patient's specific Faith/Denomination while growing-up: _____

Patient's current Faith: ☐ Christian (Practicing) ☐ Christian (Non-practicing) ☐ Atheist ☐ Agnostic ☐ Other _____

Does Patient consider themselves to be Born-again? ☐ No ☐ Yes If so, at what age? _____

Patient's current Faith/Denomination: _____

Name of Church Patient currently attends: _____ How long Attended: _____

Name of Current Pastor/Minister: _____ How well does Pastor know Patient: _____

Patient's greatest Spiritual Strength: _____

Patient's greatest Spiritual Struggle: _____

Describe Patient's belief about, and relationship with, God: _____

Patient's Current Spiritual Involvement:	Never	Rarely	Monthly	Weekly	Daily	Multiple x Day
Bible Class Attendance	☐	☐	☐	☐	☐	☐
Bible Reading/Study	☐	☐	☐	☐	☐	☐
Christian Clubs (AWANA, etc.)	☐	☐	☐	☐	☐	☐
Devotionals	☐	☐	☐	☐	☐	☐
Listening to Christian Music	☐	☐	☐	☐	☐	☐
Pray	☐	☐	☐	☐	☐	☐
Reading Christian Books	☐	☐	☐	☐	☐	☐
Watching Christian Movies	☐	☐	☐	☐	☐	☐
Worship / Church Attendance	☐	☐	☐	☐	☐	☐

Current Marriage/Family Involvement:	Never	Rarely	Monthly	Weekly	Daily	Multiple x Day
Bible Class Attendance	☐	☐	☐	☐	☐	☐
Bible Reading/Study	☐	☐	☐	☐	☐	☐
Christian Clubs (AWANA, etc.)	☐	☐	☐	☐	☐	☐
Family Devotionals	☐	☐	☐	☐	☐	☐
Listening to Christian Music	☐	☐	☐	☐	☐	☐
Family Prayer	☐	☐	☐	☐	☐	☐
Reading Christian Books	☐	☐	☐	☐	☐	☐
Watching Christian Movies	☐	☐	☐	☐	☐	☐
Worship / Church Attendance	☐	☐	☐	☐	☐	☐

Please use back of pages to provide any additional information you feel is important, but not asked about in Questionnaire.

_____ _____

Patient's Signature Date

FOR CLINICIAN'S NOTATIONS:

_____ _____

Reviewing Clinician's Signature Date