LAKEVIEW CHURCH

Adult Lakeview Counseling Intake Form

Name: _____ Date: _____

Gender: ☐ Male ☐ Female Age: _____ Date of Birth: _____

Phone Number: _____ Address: _____

Are we allowed to contact and leave messages on this number? ☐ Yes ☐ No

How did you hear about Lakeview Counseling: _____

Do you regularly attend church, synagogue or other religious institutions? ☐ Yes ☐ No

If yes, which one? _____ Frequency of church attendance: _____ times/month

Have you been baptized? ☐ Yes ☐ No When? _____

How often do you pray to God? ☐ Never ☐ Occasionally ☐ Often How often: _____

Relational Information

Current marital status: ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If engaged, married, separated, divorced, or widowed, for how long? _____

If applicable, number of previous marriages for you: _____ For your spouse: _____

If married, spouse's name: _____

Is your spouse supportive of you seeking counseling? ☐ Yes ☐ No ☐ Unsure ☐ Spouse doesn't know

Please provide a brief description of your spouse: (e.g. angry and controlling; outgoing and supportive)

_____

Please list your children below (include step, adopted, and foster):

Name	***Sex***	***Age or yr of death***	***Relationship to you:***	***Living with:***

Who else lives with you? _____

List family members who had a significant impact on your life (either positive or negative):

Name	***Sex***	***Age or yr of death***	***Relationship to you:***	***Describe him/her:***

Counseling or Mental Health History

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the names of the therapists or programs.

Therapist's Name or Program	***Dates***	***Outcome and Diagnosis***	***Medications Prescribed (if any)***

Personal Habits and Health

Approximately, how many hours of sleep do you get each night? _____

If there is a length of time between going to bed and falling asleep, what do you do during that time?

_____

_____

Are you presently taking any medications? ☐ Yes ☐ No

For what reasons? _____

Are you taking the medications as prescribed? ☐ Yes ☐ No

Have you used drugs other than for medical purposes? ☐ Yes ☐ No

When: _____ What: _____ Amount/Dosage: _____

Do you drink alcoholic beverages? ☐ Yes ☐ No

How much: _____ How often: _____

Have you ever been arrested? ☐ Yes ☐ No

What was the outcome? _____

Have you ever had a severe emotional upset? If so, explain: _____

_____

Present Concerns and Goals

Please describe why you are coming to counseling (i.e. what are your issues, symptoms, how long, etc.):

_____

_____

_____

_____

Please circle any of the following symptoms or problems that you currently are or recently have experienced:

List 1	***List 2***	***List 3***
Stress	Marital Problems	Compulsive behaviors
Anxiety	Relationship Issues	Seeing things other don't
Panic	Physical Abuse	Hearing Voices
Depression	Emotional Abuse	Racing thoughts
Lack of Interest	Verbal Abuse	Eating problems
Fatigue	Sexual Abuse	Drug Use
Loss of Appetite	Gender Identity Issues	Alcohol use
Overeating	Anger	Pregnancy
Poor concentration	Aggressive Behavior	Abortion
Trouble sleeping	Bad dreams	Legal Matters
Feeling Worthless	Flashbacks of memories	Work Stress
Grief	Impulsive behavior	Career Choices
Chronic Pain	Controlling	Indecisiveness
Loneliness	Controlled by others	Parenting problems
Fear	Obsessive Thoughts	Financial problems
Low Self-Esteem	Other	Spiritual problems

Have you ever thought about or attempted to harm yourself? (Current or in the past) ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Have you ever experienced homicidal thoughts? (Current or in the past) ☐ Yes ☐ No

If yes, please explain: _____

_____

What outcome are you hoping to gain from the counseling experience? _____

_____

_____

_____