New Path Christian Counseling

3917 E. Memorial Road Edmond, OK 73013

INTAKE FORM
(Please complete a separate form for each person coming to counseling)

Date: _____

Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Email Address_____

Address_____ Phone: _____

May we call you there? _____ Leave a voice mail? _____ May we text you at this number? _____

Occupation_____ Phone: _____

Emergency Contact _____ Phone: _____
(Name and Relationship)

Status (circle all that apply): Single Dating Engaged Married Remarried Separated Divorced Widowed Cohabitating

Partner's Name: _____ Occupation _____ Spouse's Age: _____

Persons living with you:

Name	Age	Relationship	Where do they live?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has your partner or other family member ever been physically violent toward you? Yes ☐ No ☐

Religious Preference: _____

Have you been in counseling previously? YES ☐ NO ☐ Was it helpful to you? _____

If so, please provide the name of the counselor you saw: _____

Are you currently in counseling? YES ☐ NO ☐

If so, please provide the name and location of the counselor: _____

If you answered yes to either of the previous questions, please answer the following:

a. How long have you been in counseling? Years _____ Months _____

b. How many counselors have you seen? _____

c. Was counseling for the treatment of the current problem? YES ☐ NO ☐

Were you referred here? YES ☐ NO ☐ If yes, by whom: _____

How did you hear about this Clinic? _____

Are you on any type medication? YES ☐ NO ☐

If yes, what medication: _____

Briefly describe your current physical health and any health problems currently being treated:

Who is your physician? _____

Previous major illnesses or major hospitalizations:

Current or Past History with Alcohol and/or Drug Abuse (Please Explain):

Please indicate with a check mark any of the following issues that are a concern for you at this time or have been a concern in the past. Please rank the three [3] **most important** concerns from 1, 2, 3 with 1 being the most urgent.

___ Career concerns
___ Academic concerns
___ Self-esteem
___ Grief
___ Depression
___ Sleeping difficulty
___ Eating difficulty
___ Eating disorders
___ Anxiety
___ Stress
___ Panic attacks
___ Self Injury
___ Physical abuse
___ Emotional abuse
___ Child sexual abuse
___ Sexual assault
___ Sexual concerns
___ Sexual orientation concerns
___ Alcohol abuse
___ Other drug abuse
___ Social concerns
___ Culture related issues
___ Dependency
___Homesick
___ Relationship issues
___ Parent difficulty
___ Suicidal thoughts/behavior
___ Homicidal thoughts/behavior
___ Anger control
___ Violent behavior
___ Paranoia
___ Excessive fears
___ Obsessive thoughts/behavior
___ Compulsive thoughts/behavior
___ Hallucinations
___ Pornography

Brief statement of concern (Why are you seeking counseling? What would you like to see different in your life as a result of counseling?)

Is there any additional information you feel would help a therapist better understand your needs?

_____ _____

Signature Date

_____ _____

Signature Date