All question contained in this questionnaire will be kept strictly confidential

Client Information Form

Welcome. I look forward to providing you with excellent and efficient counseling services. Please take a few minutes to fill out this form, the information will help me better understand your situation as well as how best to help you get the service(s) you need. Your information is confidential and will not be released to anyone without your written permission.

Today's date: (Intake Date) _____ **time** _____

Type of services being sought (Check all that apply): ☐ Individual adult - ☐ Individual child
☐ Marital/Couple ☐ Family

Referral Source: ☐ Insurance ☐ School ☐ Internet ☐ Friend/Relative ☐ Court/Probation

Identified Client

Person filling out form: _____ _____ _____ age: ___ DOB: _____
Name of Primary Client (If Different):_____Relationship __ Age: ___ DOB: _____
Address: _____ _____City _____ZIP_____
Home phone: _____Work ph. _____cell _____ email _____
Single____married____divorced___minor____employed___retired____student____

May I send material/information to your home? Yes ___ No _____

Name of Individuals living in household

Last, First, Initial	Relationship	Birth Date	Employment/School & Grade	Ethnicity

Second Household (Additional household members/children outside the Home (if Applicable)

Name: _____Relationship: ____ Age: ____ DOB _____

Address: _____City _____ZIP_____

Name: _____Relationship: ____ Age: ____ DOB _____

Address: _____City _____ZIP_____

Name: _____Relationship: ____ Age: ____ DOB _____

Address: _____City _____ZIP_____

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Financial information

Counseling private fees or co-payments are due at the time of service.

Individual responsible for payment _____

address (If different from above) _____

Relationship to client _____

Phone nr (If different from above) _____

I agree to pay the family ministry the amount of _____ per session for counseling services: (Signature of responsible private pay person):

Signature: _____ Date: _____

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personal health history

Have you /anyone in the family attended therapy or are currently in treatment? Yes ____ no _____

List any medical problems that doctors have diagnosed:

Is anyone in the family being treated for a serious medical problem? Yes ____ no____

Alcohol

Do you drink alcohol? …… Yes___ No _____

If yes, what kind? _____ How many drinks per week? _____

Are you concerned about the amount you drink? …… Yes ____No _____

Have you considered stopping? …… Yes ___ No _____

Have you ever experienced blackouts? …… Yes ___ No _____

Are you prone to "binge" drinking? …… Yes ___ No _____

Do you drive after drinking? …… Yes __ No _____

Do you drink alone? …… Yes __ No _____

Do you have a family member who has alcohol or other substance abuse issues? Yes _____no _____

Tobacco

Do you use tobacco? ……Yes __No ___

Cigarettes (packs per day): ___ Chew – (nr per day): ___ Pipe (times per day): _____

Cigars (nr per day): ___number years smoked: _____or year quit smoking: _____

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Drugs

Do you currently use recreational or street drugs? Yes____ No ____

Have you ever given yourself street drugs with a needle? Yes ____No ____

Questions contained in this questionnaire will be kept strictly confidential

MENTAL HEALTH)

Is stress a major problem for you? …… Yes __ N0

Do you feel depressed? …… Yes __ No

Do you panic when stressed? …… ……. Yes __ No

Do you have problems with eating or your appetite? ……Yes __No

Do you cry frequently? …… Yes __No

Have you ever attempted suicide? …… Yes __No

Have you ever seriously thought about hurting yourself? …… .…….Yes __No

Do you have trouble sleeping? …… Yes __No Have you ever been to a counselor (Mental health or Marriage)? ……Yes __No

Do you practice a religion? ……Yes __No

Do you pray? ___ Do you believe in forgiveness? ___Is grace a reality for you? _____

Do you think everything happens for a reason?
If so, what is the reason?
Is there a reason to be kind to others?
If so, what is the reason?

Has anyone in the family attempted suicide, recently or in the past? _____

Has anyone in the family been a victim or perpetrator of child abuse (Physical, emotional, neglect), domestic violence, rape, or other violent act? _____

Relationship Inventory

Do one of you get angry or hurt when here is different perspective /point of view?
Yes _____ NO _____
Do one of you experience anxiety when there is a different of opinion?
Yes _____ NO _____

Reason for Visit

What are the primary concerns that bring you here?

The following acknowledgement and release is required

I acknowledge and understand that the time of my scheduled appointment IS reserved for me. If I need to cancel, I must give a 24 hour notice. I understand that I may be charged the full session fee (75.00) for late cancellation and missing an appointment without notifying Dr. Lewis. If Dr. Lewis cancels, less than 24 hours or misses an appointment, you are entitled to a session without charge.

I authorize the release of information necessary to process insurance claims, when applicable, for counseling services.

Client/ or Caregiver's Signature:	Date:

Privacy Policy Acknowledgement

Must be signed by all adult participants in therapy

I have read and understand the **Notice of Privacy Practices** (copies available in waiting area and online). I understand that I may request a copy of this policy for my records. I understand that I may ask my therapist about the policy if I have any questions now or in the future.

Client/ or Caregiver's Signature:	Date: