CCS INTAKE FORM

(to be completed by new clients and former clients not seen in the past 12 months)

Please fill out the form as completely as you can. The information requested in this form will help your counsellor assist you. It will also be kept confidential.

General Information

Last Name: _____ First Name: _____

Birth Date: _____ Age: _____ Gender: Male / Female (circle one)

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Work Phone:_____ Cell Phone: _____

Guardian / Parent (if under 18):

Employment/Education Information

Full-time employee _____ Part-time employee _____ Self-employed _____ Unemployed _____

Occupation: _____ Length of employment: _____

Highest level of education completed (circle one): High School College Degree Graduate Degree

Family Information

Relationships (circle one): Single Engaged Co-Habiting Married Separated/Divorced Widowed Remarried

Name of Spouse/Partner: _____ Anniversary Date: _____ Number of Years Married:_____

Names/Ages of Children:

Have any of your children died? _____ If so, when: Child's age at time of death:

Definition of concern(s) that brought you to counselling:

What is your reason for seeking counselling today?

What would you like to see happen as a result of your counselling experience?

If any of these statements are true, please check the one(s) that apply:

____ I have thoughts of harming myself or others.

____ Thoughts of harming myself or others are a frequent occurrence.

____ I dwell on these thoughts and wonder if I can control them.

____ I have sought professional help because of these thoughts or feelings.

(PLEASE TURN OVER)

Are any of the following conditions a concern to you at this time? (Circle all those that apply)

Anxiety	Sexual concerns	Rage
Grief	Loss of work/job	Relationship with parents
Depression	Self esteem	Relationship with children
Irrational fears	Stress	Loss of meaning in life
Nervousness	Substance abuse	Loss of faith in God
Loneliness	Chronic fear	Conflicts at work
Anger	Guilt feelings	Spiritual doubts
Marriage Problems	Suicidal feelings	Other (list):
	Loss of hope	

Medical/Psychological History

Name and address of your physician:

When was your last medical examination?

Are you currently suffering any physical illnesses or symptoms or have you in the recent past? (If so, list them below)

List current medications:

Name & Dosage: _____ Date prescribed: _____

Name & Dosage: _____ Date prescribed: _____

Name & Dosage: _____ Date prescribed: _____

Name & Dosage: _____ Date prescribed: _____

Have you, or any member of your family, received help for drug or alcohol dependency? **Yes** **No**

If so, when? _____ Name of clinic/rehabilitation program: _____

Have you received counselling in the past? **Yes** **No** If so, when?

Are you currently seeing a counsellor elsewhere? **Yes** **No**

How did you hear about CCS?

Reason for choosing Christian Counselling Services:

Religious/denominational preference:

Church/Faith Community:

Name of Pastor, Priest, Religious Leader:

_____ _____

Signature **Date**