# CHRISTIAN COUNSELING ASSOCIATES

501 East 15th Street, Suite 102
Edmond, Oklahoma 73013
(405) 285-9880

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Oklahoma City, Oklahoma 73111
(405) 286-9847

## COMPREHENSIVE ADULT INTAKE
## CONFIDENTIAL

NAME_________________________________ EMERGENCY CONTACT___________________________

## CURRENT LIVING SITUATION

Children Living at home:

Name:______________________ Age:_______ Name:______________________ Age:_______

Name:______________________ Age:_______ Name:______________________ Age:_______

Name:______________________ Age:_______ Name:______________________ Age:_______

Others Living in Home:

Name:______________________ Relationship:_____________________

Name:______________________ Relationship:_____________________

Children Living Outside of Home:

Name:______________________ Age:_______ Name:_____________________ Age:________

Name:______________________ Age:_______ Name:_____________________ Age:________

## PRESENTING PROBLEM/HISTORY OF PRESENTING PROBLEM

Who referred you?______________________________________________________________________________

Please write a couple of sentences concerning the reason for your request of services.

_______________________________________________________________________________________________

_______________________________________________________________________________________________

_______________________________________________________________________________________________

**Yes**___ **No**___ Have you served in the military?

**Yes**___ **No**___ Are you currently serving in the military?

**Yes**___ **No**___ Are you currently receiving government assistance? Describe__________________________________

Please check all that apply: ____Medicaid ____Medicare ____SSI ____SSDI

**Yes**___ **No**___ Are you currently using tobacco products? If so, describe your use_______________________________

**Yes**___ **No**___ Are you currently using alcohol? If so, describe your use_______________________________________

**Yes**___ **No**___ Are you currently using other substances? If so, describe your use_______________________________

**Yes**___ **No**___ Have you been arrested in the past 30 days?____ 12 months?____

**Yes**___ **No**___ Have you ever experienced ___Physical abuse ___Emotional/Verbal abuse ___Neglect

___Sexual abuse/Molestation/Sexual misconduct ___I would rather not answer these

**Yes**___ **No**___ Have you ever attempted suicide? If yes, month/year________________

**Yes**___ **No**___ Have you ever had thoughts of suicide? If yes, month/year of latest thoughts_________________

## MEDICAL

**Yes**___ **No**___ Are you **currently** under the care of a physician for medical problems?

If yes, describe:_______________________________________________________________________

_______________________________________________________________________________

Physician Name:_____________________________ Phone:_________________________________

Address:_________________________________ City, State, Zip_____________________________

**Yes**___ **No**___ Are you **currently** taking medications?

If yes, list those you are **currently** taking (use back of page if needed).

| Medication | Strength/Dosage | Length Taken | Purpose & Side Effects |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Please list any allergies:______________________________________________________________

**Yes**___ **No**___ Are you **currently** receiving behavioral/mental health services elsewhere?

If yes, please provide the following:

| Date | Type* | Where | Purpose/Diagnosis |
|---|---|---|---|
| | | | |
| | | | |

* out-patient, in-patient, crisis intervention, day treatment, group, etc.

**Yes**___ **No**___ Have you received behavioral/mental health services in the past?

If yes, provide the following (use back of page if needed).

| Date | Type* | Where | Purpose/Diagnosis |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

How many self-help meetings have you attended in the past 30 days?____________________

Please include any other information you feel is important for the therapist to know.

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

## SPIRITUAL

**Personal Religious Information:**

**Yes___ No___** My spiritual beliefs are a significant factor in my life.

**Yes___ No___** I am involved in church/religion/spiritual practice. My church home is________________________

I attend (circle) Several times week Weekly Monthly Sporadically Seldom Never

My spouse attends (circle) Several times week Weekly Monthly Sporadically Seldom Never

My religious background is ____________________ My spouse's religious background is_____________________

Describe any significant religious experiences:________________________________________________________

________________________________________________________________________________________________

Describe any unexplainable experiences:____________________________________________________________

________________________________________________________________________________________________

**Yes___ No___** I have made the discovery of knowing Jesus Christ personally.

Describe your experience:_______________________________________________________________________

________________________________________________________________________________________________

**Yes___ No___** I am satisfied with my personal faith.

Additional Comments:___________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

X__________________________________________________________

Client Signature Date

X__________________________________________________________

Signature of Staff Person Completing Intake Date