fort bend community church

FBCC Counseling Center (FB4C)

Counseling Intake Form

Date: ___________________ Counselor: _______________________

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A. Personal Information

Name: ________________________________ Gender: F ____ M ____ Birth Date: ___________________

Address: ____

Phone: Home______________________________________ Cell____

May we leave a message? Yes ____ No ____ May we leave a message? Yes ___ No _____

Email Address: ____________________________________ May we email you? Yes ____ No ____

Occupation: _________________________ Stay-home parent ____ Student ____ Not-working ____

Accepted Jesus Christ as personal Lord and Savior: Yes ____ No ____ Date: ____________________

FBCC Member: Yes ____ No ____ Baptism Date: __________ Baptism Church: __________________

FBCC Small Group: ______________________________ Small Group Leader: _____________________________

Pastoral Zone: ________________________ Who referred you to FB4C: ______________________________

Sunday Worship attendance: Regular ____ Not Regular ____ None ____

Ministry Participation: Yes ____ No ____

Ministry Involvement: _______________________ Follow-Up lesson done: Yes ____ No Current ____

Marital Status: Never Married ____ Engaged ____ Married ____

Separated ____ Divorced ____ Widowed ____ Dating ____

Children: Yes ____ No ____ Number of children: _____________________

Age of Son(s): _______________________ Age of Daughter(s): _____________________

Reasons for Seeking Counseling

When did your present concern begin to be a problem for you?

Please rate the severity of your present concerns on the following scale:
Check one: Mild _____ Moderate _____ Severe _____ Totally Incapacitating _____
Others: _____

What concerns have led you to pursue counseling?

Where are your concerns causing the most problems for you? Check all that apply:
Home _____ Work _____ Marriage _____ School _____ Friends _____ Family _____ God _____
Others: _____

Physical Assessment **(Check all that apply)**

[ ] Headaches	[ ] Increased Appetite	[ ] Numbness/Tingling Feeling
[ ] Dizziness	[ ] Fatigue/Loss of Energy	[ ] Muscle Tension or Soreness
[ ] Fainting Spells	[ ] Decreased Sleep	[ ] Chest Pain or Discomfort
[ ] Indigestion	[ ] Increased Sleep	[ ] Accelerated Heart Rate
[ ] Nausea/Abdominal Distress	[ ] Hot Flashes/Chills	[ ] Panic
[ ] Bowel Disturbances	[ ] Trembling/Shaking	[ ] Shortness of Breath
[ ] Loss of Appetite	[ ] Sweating	[ ] Others _____

How would you rate your current physical health? Excellent _____ Good _____ Fair _____ Poor _____

When was your last physical examination? (Month / Day / Year) ___/___/_____

Are you currently being treated for any medical conditions? Yes _____ What? _____ No _____

Name of Physician: _____ Phone: _____
May we contact your physician? Yes _____ (If yes, please sign a 'Release of Information' form) No _____

Are you currently taking any medication(s)? Yes _____ No _____
If yes, please list all current medication(s) (including over-the-counter) and dosage(s):

Mental/Emotional Assessment **(Check all that apply)**

[ ] Sadness/Depressed Mood
[ ] Irritability
[ ] Recurring Flashbacks of Trauma
[ ] Sense of Worthlessness
[ ] Loss of Concentration
[ ] Thinking About Death
[ ] Fear of Dying
[ ] Intense Fear of Discomfort
[ ] Nightmares
[ ] Mind Going Blank
[ ] Loss of Interest of Pleasure
[ ] Hopelessness/Helplessness
[ ] Decreased Need for Sleep
[ ] Low Self-Esteem
[ ] Inability to Think
[ ] Impaired Functioning
[ ] Lack of Emotional Responsiveness
[ ] Loss of Reality
[ ] Feeling Detached from Others
[ ] Harming Yourself
[ ] Recurrent Distressing Dreams
[ ] Restlessness
[ ] Outbursts of Anger
[ ] Feelings of Shame/Guilt
[ ] Racing Thoughts
[ ] Inability to Recall Details
[ ] Feeling Detached from Self
[ ] More Talkative Than Usual
[ ] Restricted Range of Emotions
[ ] Harming Others

Do you or anyone in your family have any history of drug/alcohol abuse?
Yes _____ No _____ If yes, When? _____
Please describe briefly:

Do you or anyone in your family have any history of any serious mental health issues? (such as depression, anxiety, manic depression, schizophrenia, etc.)?
Yes _____ No _____ If yes, When? _____
Please describe briefly:

Do you or anyone in your family have any history of physical or sexual abuse towards you or others?
Yes _____ No _____ If yes, When? _____
Please describe briefly:

Have you ever been treated or hospitalized for any psychiatric reason(s)?
Yes _____ No _____ If yes, When? _____
How long? _____ Where at? _____

Name of Psychiatrist: _____ Phone: _____

Have you had prior counseling/therapy? Yes _____ No _____
If Yes, When? _____
If Yes, how long? _____ Name of Counselor/Organization: _____
Reason for counseling? _____

If Yes, how do you feel about the results of your previous counseling/therapy?

If it should be necessary, will you sign a release form so your counselor may request for your social or psychiatric reports?

What I hope to gain from counseling at FB4C?

Intake Evaluation:

Refer to outside Mental Health Provider: