

PLEASE PRINT ALL INFORMATION

1

FAMILY AND PERSONAL INFORMATION

1. FAMILY INFORMATION:

RELATIONSHIP STATUS: (Please check all that apply.)

() Single () Married () Partnered () Separated () Divorced () Widowed

(a) INFORMATION ON SPOUSE/PARTNER

NAME OF SPOUSE/PARTNER: _____

BIRTH DATE (mm/dd/yyyy): ____/____/____

RELIGIOUS AFFILIATION/DENOMINATION: _____

OCCUPATION _____ OFFICE TELEPHONE: _____

DATE OF MARRIAGE/COMMITMENT CEREMONY (mm/dd/yyyy): ____/____/____

(b) INFORMATION ABOUT YOUR CHILDREN (Please list each child's name, birth-date and relation)

WITH WHOM DO ANY MINOR CHILDREN RESIDE: _____

2. PERSONAL INFORMATION:

ETHNICITY (Please check)

() African-American () Arab () Asian () Caucasian () Jewish () Latina(o)

() Native American/Indigenous () Other: _____

FAITH INFORMATION

Church membership or faith community affiliation: _____

Religious denomination (if any): _____

Religious upbringing (please describe): _____

Role of faith in your life (please check):

() Very Important () Important () Minor role () None

EDUCATIONAL BACKGROUND

Circle last year completed: Elementary/Middle School: 1 2 3 4 5 6 7 8

High School: 9 10 11 12

College: 1 2 3 4 5 6+

Other training (list type and number of years): _____

Military (list branch of service and years): _____

HEALTH INFORMATION

Rate your physical health: () Very Good () Good () Average () Declining

Your approximate weight: _____ lbs. Approximate Height: _____

Have you had any significant weight changes lately? Lost _____ Gained _____

List all important present or past illnesses or injuries:

Your physician: _____ Office Phone: _____

Physician's Address: _____

Are you presently taking any prescription medication(s)? Yes _____ No _____

If Yes, please list and briefly explain:

Drug and Alcohol Use

Please list your use of caffeine, tobacco, alcohol, marijuana and other drugs over the last month:

Please check your response to the following questions:

1. Have you ever felt a need to cut down on your drinking or drug use? () yes () no
2. Have people ever annoyed you by criticizing your drinking or drug use? () yes () no
3. Have you ever felt bad or guilty about your drinking or drug use? () yes () no
4. Have you ever had a drink or used drugs in the morning to steady your nerves or get rid of a hangover? () yes () no

CLIENT SELF-ASSESSMENT

Please circle the description that is most appropriate for you:

YOUR MOOD?

Extreme Depression	Down, Low	Content	Happy	Extremely Happy
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YOUR SENSE OF PLEASURE AND INTEREST IN ACTIVITIES?

None	Poor	Average	Good	Excellent
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FEELINGS OF GUILT?

Excessive	Some	Little	Rare	None
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YOUR ENERGY LEVEL?

None	Poor	Average	Good	Excessive
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YOUR CONCENTRATION?

Extremely Poor	Poor	Average	Good	Excellent
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YOUR SLEEP?

Extremely Poor	Poor	Average	Good	Excessive
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YOUR APPETITE?

None	Poor	Average	Good	Excessive
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Have you ever experienced thoughts of hurting yourself or others?
(please check your response) () yes () no

If yes, please explain: _____

STRESSORS

Instructions: Please place a (v) in one of the boxes (Not Present, Mild, Moderate, Severe, or Extreme) for each of the stressors in the following list. Use the check list to indicate how much stress you have been under during the past year. Be sure to check one of the boxes for every one of the stressors. Use the "Not Present" column if you have not experienced a specific type of stress during the past year.

List of Stressors	Not Present	Mild	Moderate	Severe	Extreme
1. Beginning/Ending Employment					
2. Job problems					
3. Conflict with boss or co-worker					
4. Retirement					
5. Move					
6. Couple/Partner					
7. Infertility					
8. Birth or adoption of child					
9. Separation or divorce					
10. Death of loved one					
11. Physical illness					
12. Caregiver issues					
13. Financial problems					
14. Conflict with family member					
15. Sexual problems or infidelity					
16. School problems					
17. Legal problems					
18. Addictions					
19. Other:					

Are you currently impacted from any past stressor or trauma that we should be aware of?
() yes () no

If yes, please explain: _____

If yes, how does this past stressor or trauma currently impact your life?

PAYMENT INFORMATION

Who will be responsible for charges incurred?

_____ Client _____ Other (please list contact information below:

Name: _____

Address: _____

Phone: _____

The Louisville Seminary Counseling Center (LSCC) initial session fee is \$20.00. Counseling session fees range from \$10.00 to \$65.00 as established with your therapist. In the event that you are in need of financial assistance with your fee, please discuss this with your therapist.

LSCC accepts checks or cash as payment. Any returned check fee incurred by LSCC must be reimbursed by the client.

Please list your average monthly income: _____

I HEREBY CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE, THE INFORMATION PROVIDED ON THIS INTAKE FORM IS COMPLETE AND CORRECT.

SIGNATURE OF CLIENT

DATE