New Client Intake Sheet
Rock of Hope Counseling

Client Information

Name: ____ Date of Birth__________________

Address: ____

Living in household:
Name: __________________________________Relationship:_______Age/Date of Birth________

Name: __________________________________Relationship:_______Age/Date of Birth________

Name: __________________________________Relationship:_______Age/Date of Birth________

Name: __________________________________Relationship:_______Age/Date of Birth________

Please provide contact phone number(s) and indicate your preferred number.

Home Phone: ______________Leave a message? ___ yes ___ no preferred? ___ yes ___ no

Cell Phone: _______________ Ok to text? ___ yes ___ no preferred? ___ yes ___ no

Work Phone: ______________ Leave a message? ___ yes ___ no OK to call? ___ yes ___ no

E-mail(s):______________________________ OK to E-mail? ___ yes ___ no

Referred by: _____________________________

Do I have your permission to thank the person who referred you? ___ yes ___ no

RELIGIOUS AND SPIRITUAL

Do you consider yourself spiritual? Yes No religious? Yes No

Comment? ____

Do you currently express this spirituality through religious practice? Yes No

Comment? ____

Would you like spirituality included in your counseling? Yes No

ROCK OF HOPE COUNSELING

BACKGROUND AND PRESENTING PROBLEM

Occupation (s) ____
Education ____

Marital Status _____ If married, how long? ______

If you have been married before, please provide dates for marriage(s) and divorce(s):

____

Please describe briefly the problem or situation, which led you to seek our services at this time:
____
____
____
____

How long has this been a problem? ____________

Have you experienced this type of problem before? __________ If so, when?________________

Have you ever had counseling before? _________ If so, when and why?

____
____
____

Was it helpful? ______ If not, why not? ____

Have you ever had medication prescribed for psychiatric or emotional difficulties? _____________
If so, please list ____

Have any other biological relatives had problems similar to yours, or had any other psychiatric or emotional difficulties? ___ yes ___ no

If so, which relatives and what kind of problems?
____
____
____

Health history: other current medications, illnesses, hospitalizations

____
____

Presenting problems: (check all that apply-if attending couples counseling please put your initials next to the problems that apply)

___ very unhappy
___ irritable
___ temper outbursts
___ withdrawn
___ daydreaming
___ fearful
___ worry
___ overactive
___ slow
___ short attention span
___ distractible
___ lacks initiative
___ undependable
___ social problems
___ crying spells
___ hair pulling
___ impulsive
___ stubborn
___ panic attacks
___ lying
___ mean to others
___ destructive
___ trouble with the law
___ health problems
___ self-mutilating
___ stressed out
___ relationship problems
___ shy
___ strange behavior
___ strange thoughts
___ physical abuse
___ sexual abuse
___ parenting problems
___ stealing
___ repetitive/ritualistic behaviors
___ grief
___ employment problems
___ financial stress
___ legal problems
___ violence
___ eating problems
___ sleeping problems
___ sexual problems
___ drug use
___ alcohol use
___ suicidal thoughts
___ homicidal thoughts

Explain:

____

____

____

____

What are your goals for treatment?

____

____

____

____

Is there anything else you feel is important for your counselor to know?

____

____