TRUE COLORS APOSTIC CENTER

TRUE COLORS MINISTRY, INTERNATIONAL
CLIENT COUNSELING INTAKE FORM

Today's Date:_____

Client's Name (Counselee):_____ Age:_____ Birth Date:_____

Parent/Guardian's Name(s):_____ Age(s):_____

Address:_____

City:_____ State:_____ Zip:_____

Phone: (Home)_____ (Work):_____ Best time to Call:_____

Marital Status: ☐ Single ☐ Engaged ☐ Married How Long:_____ How Many Times:_____
☐ Separated - How Long:_____ ☐ Divorced - How Long:_____

Education:_____ Occupation:_____ Social Security No:_____

Spouse's Name:_____ Age:_____ Birth Date:_____

Spouse's Education:_____ Spouse's Occupation: _____

List name, birth date, sex, relationship of all children, and whether they live at home with you.

Name:	Birth Date:	Sex:	Relationship:	At Home?

Type of Counseling: ☐ Individual ☐ Married Couple ☐ Family Who:_____

Any prior counseling: ☐ Yes ☐ No; If yes, When?_____ Where?_____

With whom?_____

State the nature of the problem in your own words:_____

_____

_____

_____

What is your most difficult relationship right now?_____

What is your most difficult emotion right now? _____

CRISIS INFORMATION:

Any current suicidal thoughts, feelings, or actions? □ Yes □ No

If yes, explain:_____

Any current homicidal or assaultive thoughts or feelings, or anger-control problems? □ Yes □ No

If yes, explain:_____

Any past problems, hospitalizations, or jailings for suicidal or assaultive behavior? □ Yes □ No

If yes, explain:_____

Any current threats of significant loss or harm (illness, divorce, custody, job loss, etc)? □ Yes □ No

If yes, explain:_____

MEDICAL INFORMATION:

Doctors' Name:_____ Phone: _____

Address:_____

Are you presently taking any medication? □ Yes □ No If so, what?_____

For what purpose?_____

Any problems with: □ Eating □ Sleeping □ Chronic Pain □ Recent Weight Changes

Describe any answers checked above:_____

Any other medical problems?_____

Have you or a family member ever been hospitalized for mental or emotional illness? □ Yes □ No

If yes please explain – dates, place, reason:_____

_____

COMMON PROBLEM/SYMPTOM CHECKLIST:

□ Marriage	□ Divorce/separation	□ Alcohol/drugs	□ God/faith
□ Premarital	□ Child custody	□ Other addictions	□ Church/ministry
□ Singleness	□ Disabled	□ Grief/loss	□ Past hurts
□ Sexual issues	□ Work/career	□ Depression	□ Codependency
□ Family	□ School/learning	□ Fear/anxiety	□ Intimacy
□ Children	□ Money/budgeting	□ Anger control	□ Communication
□ Parents	□ Aging/dependency	□ Loneliness	□ Self-esteem
□ In-laws	□ Weight control	□ Mood swings	□ Stress management

Other (specify):_____

WHO REFERRED YOU TO US: (Name, Relationship and Phone Number) _____

_____

If a professional referred you to us, may we send them a thank-you, noting your contact? □ Yes □ No
If yes, we will only send a thank-you, any other contact will require your express written permission.