Compassion Counseling Center

Intake Form

Instructions:

- Answer the following questions to the best of your ability.
- Mail the completed form to: Compassion Counseling Center
  5500 25th Ave. NW
  Rochester, MN 55901

1. Name: _____ Age: _____ Birth date: _____
   First Middle Initial Last mm/dd/yyyy

2. Address: _____ (Circle one) Male Female
   Street Address & Apt. #

   _____ _____ _____
   City State ZIP Code

3. Phone: (_____)_____ ☐ Home ☐ Cell ☐ Work

   Can we leave a message at this phone number: ☐ Yes ☐ No

4. Email: _____

5. How do you prefer to be contacted: ☐ Phone ☐ Email

6. Person to contact in case of emergency:

   Name: _____

   Address: _____

   Phone: _____ Relationship to you: _____

7. Race:
   - ☐ White
   - ☐ Black
   - ☐ Hispanic
   - ☐ Native American
   - ☐ Pacific Islander
   - ☐ Asian
   - ☐ Other: _____

8. Education level completed:
   - ☐ High School
     Last grade completed: _____
   - ☐ GED
   - ☐ Junior College
   - ☐ Vocational School
   - ☐ Some college
   - ☐ Four Year Degree – Major: _____
   - ☐ Graduate Degree - Subject: _____
   - ☐ Post-Graduate – Subject: _____

9. Current employment status:
   - ☐ Employed Full-Time
   - ☐ Employed Part-Time
   - ☐ Self-employed
   - ☐ Retired
   - ☐ Unemployed
   - ☐ Disability Assistance
   - ☐ Stay Home Parent
   - ☐ Other: _____

10. Marital status:
    - ☐ Single
    - ☐ Domestic Partner
    - ☐ Married
    - ☐ Separated
    - ☐ Divorced
    - ☐ Remarried
    - ☐ Widowed

11. Number of children: _____ Ages: _____/_____/_____/_____/_____/_____/_____

12. Who recommended you seek counseling?
- ☐ Self-Referred
- ☐ Spouse
- ☐ Family member
- ☐ Friend
- ☐ Physician
- ☐ Other, please specify: _____

13. What is the main issue you are seeking counseling for?

_____

_____

14. How long have you had symptoms/problems related to the current issue? _____

15. What has prompted you to seek help at this time?

_____

_____

16. What areas of your life are affected by your symptoms/problem? Check all that apply.
- ☐ Work
- ☐ School
- ☐ Marital/Significant Other Relationship
- ☐ Other Close Relationships
- ☐ Personal Hygiene
- ☐ Household Duties
- ☐ Social/Leisure Activities
- ☐ Other, please specify: _____

17. Have you been diagnosed with any of the following? Check all that apply.
- ☐ Addiction of any kind
  eg. gambling, sexual, pornography,
  alcohol, drugs/chemicals – street or prescription
  Please specify: _____
- ☐ Anxiety Disorder
- ☐ Autism Spectrum Disorder
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Eating Disorder
- ☐ Impulse Control Disorder
- ☐ Learning Disorder
- ☐ Obsessive Compulsive Disorder
- ☐ Panic Attacks
- ☐ Personality Disorder
- ☐ Post-Traumatic Stress Disorder
- ☐ Schizophrenia
- ☐ Sleep Disorder
- ☐ Sexual Disorder
- ☐ Substance Abuse
- ☐ Thinking/Memory Disorder
- ☐ Other – please specify _____

18. Are you **CURRENTLY** receiving treatment or care for any mental or emotional conditions **excluding** addiction?
Yes _____ No _____ If yes, who is your care provider and what facility is he/she affiliated with?
_____
Have you **PREVIOUSLY** received treatment for any mental or emotional conditions excluding addiction?
Yes _____ No _____ If yes, please provide the information below.

Facility or Care Provider	Inpatient or Outpatient	Admission & Discharge Dates	Diagnosis	Discharged with approval of provider? Yes/No

19. Are you **CURRENTLY** receiving treatment or care for any type of addiction?

Yes _____ No _____ If yes, who is your care provider and what facility is he/she affiliated with?

_____

Have you **PREVIOUSLY** received treatment for any type of addiction?

Yes _____ No _____ If yes, please provide the information below.

Facility or Care Provider	Inpatient or Outpatient	Admission & Discharge Dates	Diagnosis/Addiction	Discharged with approval of provider? Yes/No

Have you maintained sobriety or abstinence from addictive behavior? Yes _____ No _____

If yes, for how long? _____

What do you do to maintain your sobriety/abstinence?

_____

_____

If no, what prevents you from maintaining sobriety/abstinence?

_____

_____

20. Are you on any medications?

☐ Yes, please list:

Medication	Dose

☐ No

21. Are you involved in any current legal issues?

☐ Yes, please specify:

_____

_____

☐ No

22. What symptoms/problems are you **CURRENTLY** experiencing or **HAVE** in the past experienced? Check all that apply.

- ☐ Chronic Physical Illness
  - ☐ Cancer
  - ☐ Traumatic Head Injury
  - ☐ Diabetes
  - ☐ Heart Disease
  - ☐ Seizure Disorder
  - ☐ Thyroid Disease
  - ☐ Other: _____
- ☐ Frequent Pain
  - ☐ Abdominal Pain
  - ☐ Arthritis
  - ☐ Fibromyalgia
  - ☐ Migraines
  - ☐ Other: _____
- ☐ Physical Symptoms
  - ☐ Chest Pains
  - ☐ Headaches
  - ☐ Nausea
  - ☐ Weight Gain/Loss of More Than 10 Pounds in the Last 6 Months
  - ☐ Other: _____
- ☐ Sleep Disturbances
  - ☐ Difficulty Falling Asleep
  - ☐ Frequent Awakening
  - ☐ Sleep Too Little: Number of hours _____
  - ☐ Sleep Too Much: Number of hours _____
  - ☐ Obstructive Sleep Apnea
  - ☐ Other: _____
- ☐ Abuse
  - ☐ Emotional
  - ☐ Physical
  - ☐ Sexual
  - ☐ Spiritual
- ☐ Anger
- ☐ Convictions
  - ☐ Misdemeanor
  - ☐ Felony
  - ☐ Other: _____
- ☐ Financial Problems or Stresses
- ☐ Grief
- ☐ Lack/Loss of . . .
  - ☐ Ambition/Motivation
  - ☐ Concentration or Memory
  - ☐ Joy/Pleasure
  - ☐ Family Member/Friend
  - ☐ Spiritual Connection/ Relationship With God
- ☐ Life Transition
  - ☐ Adoption
  - ☐ Career/Job Change
  - ☐ Unemployment
  - ☐ Elderly Parents
  - ☐ Empty Nest
  - ☐ Graduation
  - ☐ New Child
  - ☐ Retirement
  - ☐ Single Parent
  - ☐ Other: _____
- ☐ Loneliness/Sadness
- ☐ Military Service
  - ☐ Combat
  - ☐ Combat Injury
- ☐ Pregnancy Issues
  - ☐ Infertility
  - ☐ Loss of Pregnancy
  - ☐ Teenage Pregnancy
  - ☐ Termination (Post-Termination Issues)
  - ☐ Unplanned Pregnancy
  - ☐ Other: _____
- ☐ Relationship Issues
  - ☐ Blended Family
  - ☐ Children
  - ☐ Divorce
  - ☐ Friends
  - ☐ Infidelity
  - ☐ Parents
  - ☐ Rejection
  - ☐ Spouse/Partner
  - ☐ Separation
  - ☐ Supervisor/Teacher
  - ☐ Teenagers
  - ☐ Work Environment
  - ☐ Other: _____
- ☐ Self-Esteem
- ☐ Sexual Difficulties/Issues
  - ☐ Erectile Dysfunction
  - ☐ Gender Identity
  - ☐ Loss of Interest
  - ☐ Pornography
  - ☐ Promiscuity
  - ☐ Unfaithfulness
  - ☐ Other: _____
- ☐ Addictive Behavior
  - ☐ Alcohol
  - ☐ Cigarettes
  - ☐ Gambling
  - ☐ Illegal Drugs
  - ☐ Marijuana
  - ☐ Pornography
  - ☐ Prescription Drugs
  - ☐ Sexual
  - ☐ Other_____
- ☐ Anxiety and/or Panic
  - ☐ Intrusive Thoughts
  - ☐ Panic Attacks
  - ☐ Social Anxiety
  - ☐ Fears
  - ☐ Phobias
- ☐ Disturbing Habits
  - ☐ Checking
  - ☐ Hand Washing
  - ☐ Hoarding
  - ☐ Other: _____
- ☐ Disturbing Thoughts (hearing or seeing things that others do not see or hear)
- ☐ Eating Issues
  - ☐ Anorexia
  - ☐ Bulimia
  - ☐ Compulsive Eating
  - ☐ Overeating
  - ☐ Binging
  - ☐ Loss of Appetite
- ☐ Flashbacks to Trauma
- ☐ Mood Changes
- ☐ Perfectionism
- ☐ Suicidal Thoughts
- ☐ Homicidal Thoughts

23. Do you feel safe in your home? Yes _____ No _____

For questions 24 through 30, circle the number that most closely fits you.

24. How important are spiritual/faith issues in counseling?

Not at all important — Somewhat Important — Very important

1 — 2 — 3 — 4 — 5

25. How important is prayer?

Not at all important — Somewhat Important — Very important

1 — 2 — 3 — 4 — 5

26. My life is filled with meaning.

Disagree — Neutral — Strongly Agree

1 — 2 — 3 — 4 — 5

27. I have hope for the future.

Disagree — Neutral — Strongly Agree

1 — 2 — 3 — 4 — 5

28. I find meaning in relationships with others.

Disagree — Neutral — Strongly Agree

1 — 2 — 3 — 4 — 5

29. I find meaning in artistic or musical pursuits.

Disagree — Neutral — Strongly Agree

1 — 2 — 3 — 4 — 5

30. I find meaning in physical or sport pursuits.

Disagree — Neutral — Strongly Agree

1 — 2 — 3 — 4 — 5

31. Do you have specific faith beliefs?

- ☐ Yes, check all that apply:
  - ☐ Agnostic
  - ☐ Atheist
  - ☐ Buddhism
  - ☐ Christianity, please specify denomination:_____
  - ☐ Hinduism
  - ☐ Islam
  - ☐ Judaism
  - ☐ Occult, please specify: _____
  - ☐ Other, please specify: _____
- ☐ Not sure

32. Are you involved in a faith community or place of worship?

☐ Yes ☐ No

33. Are you satisfied with your spiritual growth?

☐ Yes ☐ No

34. Is there anything else that you want your counselor to know?

_____

_____

_____

_____

_____

_____

_____

_____

35. Have you ever submitted an intake form to the Compassion Counseling Center before? (Circle one) Yes No

If yes, and your name has changed, please provide your former name: _____

36. How did you hear about the Compassion Counseling Center?

- ☐ Brochure
- ☐ Church
- ☐ Friend
- ☐ Internet
- ☐ Newsletter
- ☐ Other _____

37. Appointment Preferences:

I will be available for counseling at the following times (s). Please mark all possibilities so we can quickly schedule you for an appointment.

Thursday:

7:00 pm _____

8:00 pm _____

Male Counselor requested _____

Female Counselor requested _____

No Preference _____

Every effort will be made to honor your preferences.

_____ _____

Signature mm/dd/yyyy

Thank you for completing the Intake Form.

Please return to: Compassion Counseling Center
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Rochester, MN 55901