Compassion Counseling Center - Intake Form

Please answer the following questions to the best of your ability, then mail the completed form to:

Compassion Counseling Center
5500 25th Ave. NW
Rochester, MN 55901

Full Name: _____ Age: _____ Birth Date: _____

Gender: ☐ Male ☐ Female Phone: (_____)_____ Can we leave a message? ☐ Yes ☐ No

Email: _____ How do you prefer to be contacted? ☐ Phone ☐ Email

Address: _____ City: _____ State: _____ Zip: _____

EMERGENCY CONTACT

Emergency Contact Name: _____ Phone: (_____)_____

Address: _____ Relationship to you: _____

ETHNICITY

☐ White ☐ Black ☐ Hispanic ☐ Native American ☐ Pacific Islander ☐ Asian ☐ Other: _____

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: _____

CURRENT EMPLOYMENT STATUS

☐ Employed Full-Time
☐ Employed Part-Time
☐ Self-employed
☐ Retired
☐ Unemployed
☐ Disability Assistance
☐ Stay Home Parent
☐ Other: _____

MARITAL STATUS

☐ Single ☐ Domestic Partner ☐ Married ☐ Separated ☐ Divorced ☐ Remarried ☐ Widowed

NUMBER OF CHILDREN: _____ Ages: _____/_____/_____/_____/_____/_____/_____

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Who recommended you seek counseling?

☐ Self-Referred ☐ Spouse ☐ Family member ☐ Friend ☐ Physician ☐ Other: _____

What is the main issue you are seeking counseling for?

_____

_____

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

What has prompted you to seek help at this time?

_____

_____

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: _____

Have you been diagnosed with any of the following? Check all that apply:

☐ Addiction of any kind (e.g. gambling, sexual, pornography, alcohol, street or prescription drugs/chemicals) 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: _____

Are you CURRENTLY receiving treatment or care for any mental or emotional conditions EXCLUDING addiction?

☐ No
☐ Yes - Care provider's name and facility: _____

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Have you PREVIOUSLY received treatment for any mental or emotional conditions excluding addiction?

☐ No ☐ Yes - Please provide the information below:

Facility or Care Provider	Inpatient or Outpatient	Admission & Discharge Dates	Diagnosis	Discharged with provider's approval?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

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

☐ No ☐ Yes - Care provider's name and facility: _____

Have you PREVIOUSLY received treatment for any type of addiction?

☐ No ☐ Yes - Please provide the information below:

Facility or Care Provider	Inpatient or Outpatient	Admission & Discharge Dates	Diagnosis	Discharged with provider's approval?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Have you maintained sobriety or abstinence from addictive behavior?

☐ Yes - How long have you maintained your sobriety? _____

What do you do to maintain your sobriety/abstinence? _____

☐ No - What prevents you from maintaining sobriety/abstinence? _____

Are you on any medications?

☐ No ☐ Yes - Please List:

Medication	Dose

Are you involved in any current legal issues?

☐ No ☐ Yes - Please Specify: _____

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What symptoms/problems are you CURRENTLY experiencing or HAVE experienced in the past? 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

CONVICTIONS
- ☐ Misdemeanor
- ☐ Felony
- ☐ Other: _____

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: _____

MILITARY SERVICE
- ☐ Combat
- ☐ Combat Injury

PREGNANCY ISSUES
- ☐ Infertility
- ☐ Loss of Pregnancy
- ☐ Teenage Pregnancy
- ☐ Termination (PostTermination Issues)
- ☐ Unplanned Pregnancy
- ☐ Other: _____

RELATIONSHIP ISSUES
- ☐ Blended Family
- ☐ Children
- ☐ Divorce
- ☐ Friends
- ☐ Infidelity
- ☐ Parents
- ☐ Rejection
- ☐ Spouse/Partner
- ☐ Separation
- ☐ Supervisor/Teacher
- ☐ Teenagers
- ☐ Work Environment
- ☐ Other: _____

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: _____

EATING ISSUES
- ☐ Anorexia
- ☐ Bulimia
- ☐ Compulsive Eating
- ☐ Overeating
- ☐ Binging
- ☐ Loss of Appetite

OTHER
- ☐ Flashbacks to Trauma
- ☐ Anger
- ☐ Mood Changes
- ☐ Self-Esteem
- ☐ Perfectionism
- ☐ Financial Problems or Stresses
- ☐ Grief
- ☐ Disturbing Thoughts (hearing or seeing things that others do not see or hear)
- ☐ Loneliness/Sadness
- ☐ Suicidal Thoughts
- ☐ Homicidal Thoughts
- ☐ Other: _____

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Do you feel safe in your home? ☐ Yes ☐ No

For the following questions, circle the number that most closely fits you:

How important are spiritual/faith issues in counseling?

Not at all important — Somewhat Important — Very important

1 —— 2 —— 3 —— 4 —— 5

How important is prayer?

Not at all important — Somewhat Important — Very important

1 —— 2 —— 3 —— 4 —— 5

My life is filled with meaning.

Disagree — Neutral — Strongly Agree

1 —— 2 —— 3 —— 4 —— 5

I have hope for the future.

Disagree — Neutral — Strongly Agree

1 —— 2 —— 3 —— 4 —— 5

I find meaning in relationships with others.

Disagree — Neutral — Strongly Agree

1 —— 2 —— 3 —— 4 —— 5

I find meaning in artistic or musical pursuits.

Disagree — Neutral — Strongly Agree

1 —— 2 —— 3 —— 4 —— 5

I find meaning in physical or sport pursuits.

Disagree — Neutral — Strongly Agree

1 —— 2 —— 3 —— 4 —— 5

Do you have specific faith beliefs? Check all that apply:

☐ Agnostic
☐ Atheist
☐ Buddhism
☐ Christianity, please specify denomination: _____
☐ Hinduism
☐ Islam
☐ Judaism
☐ Not sure
☐ Occult, please specify: _____
☐ Other, please specify: _____

Are you involved in a faith community or place of worship? ☐ Yes ☐ No

Are you satisfied with your spiritual growth? ☐ Yes ☐ No

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

_____

_____

_____

_____

_____

_____

_____

Have you ever submitted an intake form to the Compassion Counseling Center before? ☐ Yes ☐ No

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

How did you hear about the Compassion Counseling Center?

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

APPOINTMENT PREFERENCES

Appointments are **weekly, every <u>Monday</u> evening.**

Time Preference:

☐ 7:00 p.m.

☐ 8:00 p.m.

Counselor Preference:

☐ Male Counselor Requested

☐ Female Counselor Requested

☐ No Preference

Every effort will be made to honor your preferences.

Compassion Counseling Center (CCC) has provided Christian lay counseling care since 2010. I understand that care is guided by Christian principles to heal and help people with the unconditional love of Jesus and I consent to counseling and care at Compassion Counseling Center.

Signature: _____ Date: _____

Thank you for completing the Intake Form. Please return to:

Compassion Counseling Center 5500 25th Ave. NW Rochester, MN 55901