

Please note that counseling sessions are offered on Monday evenings at 7pm or 8pm.

Please answer the following questions to the best of your ability.

Full Name: _____ Age: _____ Birth Date: _____

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

Email: _____ Preferred contact method: ☐ Phone ☐ Email

Address: _____

EMERGENCY CONTACT

Emergency Contact Name: _____ Phone: _____

Relationship to you: _____

ETHNICITY

☐ African/African American ☐ Asian ☐ Hispanic ☐ Native American ☐ Pacific Islander ☐ White

☐ Other: _____ ☐ Prefer not to answer

EDUCATION LEVEL COMPLETED

☐ High School

Last Grade Completed: _____

☐ GED

☐ Community College

☐ Vocational School/Training

☐ Some college

☐ Four-Year Degree, Major: _____

☐ Graduate Degree: _____

☐ Post-Graduate: _____

CURRENT EMPLOYMENT STATUS

☐ Full-Time

☐ Retired

☐ Work from Home

☐ Part-Time

☐ Unemployed

☐ At Home Parent

☐ Self-employed

☐ Disability Assistance

MARITAL STATUS

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

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

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:

- | | |
|---|--|
| <input type="checkbox"/> Work | <input type="checkbox"/> Personal Hygiene |
| <input type="checkbox"/> School | <input type="checkbox"/> Household Duties |
| <input type="checkbox"/> Marital/Significant Other Relationship | <input type="checkbox"/> Social/Leisure Activities |
| <input type="checkbox"/> Other Close Relationships | <input type="checkbox"/> Other: _____ |

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

- | | |
|--|---|
| <input type="checkbox"/> Addiction of any kind (e.g. gambling, sexual, pornography, alcohol, street or prescription drugs/chemicals) Please specify: _____ | <input type="checkbox"/> Obsessive Compulsive Disorder |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Panic Attacks |
| <input type="checkbox"/> Autism Spectrum Disorder | <input type="checkbox"/> Personality Disorder |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Post-Traumatic Stress Disorder |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Sleep Disorder |
| <input type="checkbox"/> Impulse Control Disorder | <input type="checkbox"/> Sexual Disorder |
| <input type="checkbox"/> Learning Disorder | <input type="checkbox"/> Substance Abuse |
| | <input type="checkbox"/> Thinking/Memory Disorder |
| | <input type="checkbox"/> Other: _____ |

Are you CURRENTLY receiving treatment or care for any mental or emotional conditions EXCLUDING addiction? ☐ No ☐ Yes - Care provider's name and facility: _____

Have you PREVIOUSLY received treatment for any mental or emotional conditions EXCLUDING addiction? ☐ No ☐ Yes - Please provide the information on the next page:

Intake Application

Facility or Care Provider	Inpatient or Outpatient	Admission & Discharge Dates	Diagnosis	Discharged with the provider's approval?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> 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 the provider's approval?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> 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 taking any medications? ☐ No ☐ Yes - Please List:

Medication	Dose

Are you involved in any current legal issues? ☐ No ☐ Yes - Please specify: _____

What symptoms/problems are you CURRENTLY 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: _____

Physical Symptoms

- ☐ Chest Pains
- ☐ Headaches
- ☐ Nausea
- ☐ Weight Gain/Loss of more than 10 pounds in the last 6 months
- ☐ Other: _____

Frequent Pain

- ☐ Abdominal Pain
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Migraines
- ☐ Other: _____

Lack/Loss Of . . .

- ☐ Ambition/Motivation
- ☐ Concentration or Memory
- ☐ Joy/Pleasure
- ☐ Family Member/Friend
- ☐ Spiritual Connection/Relationship with God

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: _____

Life Transition

- ☐ Adoption
- ☐ Career/Job Change
- ☐ Unemployment
- ☐ Elderly Parents
- ☐ Empty Nest
- ☐ Graduation
- ☐ New Child
- ☐ Retirement
- ☐ Single Parent
- ☐ Other: _____

Pregnancy issues

- ☐ Infertility
- ☐ Loss of Pregnancy
- ☐ Teenage Pregnancy
- ☐ Termination (Post Termination Issues)
- ☐ Unplanned Pregnancy
- ☐ Other: _____

Relationship Issues

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

Sexual Difficulties/Issues

- ☐ Erectile Dysfunction
- ☐ Gender Identity
- ☐ Loss of Interest
- ☐ Pornography
- ☐ Promiscuity
- ☐ Unfaithfulness
- ☐ Other: _____

Addictive Behavior

- ☐ Alcohol
- ☐ Cigarettes
- ☐ Illegal Drugs
- ☐ Prescription Drugs
- ☐ Marijuana
- ☐ Gambling
- ☐ Pornography
- ☐ Sexual
- ☐ Other: _____

Anxiety and/or Panic

- ☐ Panic Attacks
- ☐ Social Anxiety
- ☐ Fears/Phobias
- ☐ Intrusive Thoughts
- ☐ Checking
- ☐ Hand Washing
- ☐ Hoarding
- ☐ Disturbing Habits
- ☐ Other: _____

Eating Issues

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

Military Service

- ☐ Combat
- ☐ Combat Injury

Other

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

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

For the following questions/statements, 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

☐ Islam

☐ Atheist

☐ Judaism

☐ Buddhism

☐ Not sure

☐ Christianity, please specify
denomination: _____

☐ Occult, please specify: _____

☐ Hinduism

☐ 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

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

Have you 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 on Monday evenings**.

Time Preference:

☐ 7:00PM

☐ 8:00PM

Counselor Preference:

☐ Male Counselor Requested

☐ Female Counselor Requested

☐ No Preference

Every effort will be made to honor your preferences. Please call 507-208-8822 if you have questions.

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. I consent to counseling and care at Compassion Counseling Center.

Signature: _____ Date: _____

Please mail the completed application to:

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

Privacy Disclosure: Compassion Counseling Center promises to the applicant that the information provided in this document will be kept strictly confidential. No information will be sold or given to any individual or company. No information on this application will be shared with anyone other than essential CCC staff and counselors without your written consent.