DEEPER WATERS

INTAKE QUESTIONNAIRE

GENERAL INFORMATION

FULL NAME ______ DATE ______

REFERRED BY ______ Sex: MALE FEMALE

NAME YOU PREFER ______ AGE ______ DATE OF BIRTH ______

RACE ______

CONTACT INFORMATION

CURRENT ADDRESS ______

CITY ______ STATE ______ ZIP ______ May we send mail here? Y N

MAILING ADDRESS (IF DIFFERENT) ______

CITY ______ STATE ______ ZIP ______ May we send mail here? Y N

( ) ______
PHONE NUMBER — May we leave messages here? Y N

EMAIL ADDRESS ______ May we send email here? Y N

EMERGENCY CONTACT

NAME ______ RELATIONSHIP ______

( ) ______
PRIMARY PHONE NUMBER

( ) ______
ALTERNATE PHONE NUMBER

EMPLOYMENT

EMPLOYER ______ LENGTH OF EMPLOYMENT ______

OCCUPATION ______ AVG HRS WORKED PER WEEK ______

EDUCATION

Last Schooling Completed: *High School* 9 10 11 12 GED *College:* 1 2 3 4 OTHER

Are you currently in school? Y N If yes, what level? ______ DEGREE PURSUING ______

COMMUNITY

Do you have a personal support system? Y N

If yes, who? ______________________________

Do you attend a weekly church service? REGULARLY OCCASIONALLY RARELY NEVER

Is h2o your church? Y N

Do you attend a weekly Life Group? REGULARLY OCCASIONALLY RARELY NEVER

With whom do you currently live? Circle all that apply:

ALONE SPOUSE CHILDREN PARENT(S) BOYFRIEND GIRLFRIEND ROOMMATE OTHER: ________

FAMILY OF ORIGIN *List mother, father, siblings, and others who have had a significant positive or negative influence on you.*

NAME	SEX	CURRENT AGE OR YEAR OF DEATH	RELATIONSHIP TO YOU *(E.G. MOM, DAD, SIBLING, STEP)*	OCCUPATION	DESCRIBE HIM/HER

ROMANTIC RELATIONSHIP STATUS

Current relationship status: SINGLE DATING ENGAGED MARRIED SEPARATED DIVORCED WIDOWED

Sexual attractions: OPPOSITE SEX SAME SEX BOTH NEITHER // *I'm satisfied with this* *I wish this would change*

If married or dating, how long: ________ Number of previous marriages for you: ________ For your partner: ________

How long have you known your partner: ________ Partner's Age: ________ Partner's Sex: M F

What words would you use to describe your partner: ______________________________

Is your partner supportive of you seeking counseling: Y N UNSURE PARTNER DOESN'T KNOW

If separated, divorced or widowed, how long: ______________________________

Do you have children (living or deceased)? Y N *If yes, list their names and ages on the back of this page*

Have you ever placed a child up for adoption? Y N If yes, when? ______________________________

Have you ever had a miscarriage or abortion? Y N If yes, when? ______________________________

MEDICAL INFORMATION

Are you currently receiving medical treatment? Y N If yes, please specify: ______________________

List any significant conditions, illnesses, traumas, surgeries or hospitalizations you have had (Use back if necessary):

____

Current medications you are taking, including those you seldom use or take only as needed (Use back if necessary):

____

Medication: ______________ Dosage: ______________ Purpose: ______________

Medication: ______________ Dosage: ______________ Purpose: ______________

Are you taking these medications according to your doctor's recommendation? Y N If no, why?

____

REASON FOR PURSUING COUNSELING

Please briefly describe why you are coming for counseling: ______________________

____

Indicate your current level of distress by placing an "X" on the scale below *(1= very little distress; 10 = extreme distress)*

1 2 3 4 5 6 7 8 9 10

Are you currently experiencing any suicidal thoughts?: Y N Have you experienced them in the past?: Y N

Have you ever attempted suicide? Y N If yes, when and how? ______________________

____

Have any of your friends or family ever attempted or committed suicide? Y N

If yes, write when and who: ______________________

PHYSICAL SYMPTOMS *Please check any of the following symptoms that apply to you presently or in the recent past.*

	PAST	PRESENT		PAST	PRESENT		PAST	PRESENT
HEADACHES			DIZZINESS			STOMACH TROUBLE		
SEVERE ALLERGY			SLEEP TROUBLE			TROUBLE RELAXING		
WEAKNESS			PAIN			RAPID HEART RATE		
DIFFICULTY BREATHING			SEEING THINGS			HEARING VOICES		
CHANGE IN APPETITE			TIREDNESS			OTHER		

How has Your Weight Change in the Last 2-3 Months: ______________________

OTHER SYMPTOMS *Please check any of the following symptoms that apply to you presently or in the recent past.*

	PAST	PRESENT		PAST	PRESENT		PAST	PRESENT
STRESS			SEXUAL IDENTITY			SEXUAL BEHAVIOR		
PANIC			DISEASE			DEPRESSION		
GUILT/SHAME			APATHY			DEATH OF LOVED ONE		
UNWANTED DESIRES			GRIEF			HOPELESSNESS		
INFERIORITY FEELINGS			ADDICT IN HOME			LONELINESS		
MARITAL TROUBLE			DIVORCE			UNCONTROLLED LIBIDO		
EMOTIONAL ABUSE			VERBAL ABUSE			PHYSICAL ABUSE		
TEMPER			ANGER			SEXUAL ABUSE		
BAD DREAMS			CONCENTRATION			RACING THOUGHTS		
IMPULSIVE BEHAVIOR			POOR MEMORY			COMPULSIVE BEHAVIOR		
SEXUAL PROBLEMS			ANXIETY			EATING ISSUES		
DRUG USE			TRAUMA			JOB TROUBLE		
CAREER CHOICES			ALCOHOL USE			INDECISIVENESS		
RECENT LOSS			PARENTAL ISSUES			WORKAHOLISM		
ADDICTION			CODEPENDENCY			RELATIONAL CONFLICT		
ISOLATION			SELF-HARM			SOCIAL ANXIETY		
PHOBIAS			SELF-SABOTAGE			BOUNDARY ISSUES		
LYING			RAPE/SEXUAL ASSAULT			INCEST		
INFIDELITY			PORNOGRAPHY ISSUES			LEGAL ISSUES		
INFERTILITY			OVERCOMMITMENT			BODY IMAGE		
PARANOIA			FINANCES			OTHER		

PREVIOUS COUNSELING

Have you ever been to counseling before? Y N If yes, when and for how long? ______________________

Why did you attend counseling previously? ______________________

Please read & sign below.

By signing this I take full responsibility for the truthfulness (or lack thereof) of the information I have provided or withheld in filling out this questionnaire.

______________________ ______________

CLIENT'S SIGNATURE DATE