CHRISTIAN-COUNSELING-SOLUTIONS
INTAKE FORM

SECTION I – PATIENT INFORMATION

First Name _____ MI ____ Last Name _____ Today's Date _____

Home Address _____ City _____ State _____ Zip _____

Home E-Mail _____ Home Phone (____)_____

Cell Phone (____)_____ Date of Birth ____ / ____ / _____

How Did You Hear About Us?_____

Employer _____

Occupation _____ Title _____

Single _____ Married _____ Divorced _____ Living Together _____ Separated _____ Widow(er) _____

Spouses Name: First _____ MI ____ Last _____ Phone (____**)** _____

Spouses Date of Birth ____ / ____ / _____ Spouses Employer _____

Emergency Contact _____ Phone (____) _____ Relationship _____

Church Affiliation _____ Pastor _____

SECTION II – PREVIOUS PSYCHIATRIC HISTORY

Have you seen a Psychiatrist or Counselor in the past? Yes No If yes, which? _____

If Yes, for _____ # of sessions from _____/_____ to _____/_____
Month/Year Month/Year

Provider's Name	City	State	Phone	Diagnosis	Beneficial?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

MEDICAL HISTORY:

Medications currently being taken: _____

Significant illnesses and hospitalizations: _____

Reason for Your Call: _____

_____

Comments: