TPC
Integrative Psychotherapy & Pastoral Counseling

Client ID: _____

CONFIDENTIAL INTAKE FORM

Please fill out this information form as carefully and as thoroughly as possible. This information will be confidentially used by your therapist.

GENERAL INFORMATION:

_____ _____
NAME **AGE & DOB**

Name of Parent(s)/Guardian(s) if under 18: _____

EDUCATIONAL INFORMATION:

Highest level of schooling completed: ☐ High School ☐ College ☐ Graduate
☐ Professional training ☐ Currently a student, grade: _____ ☐ Other: _____
Names of College/University(ies)/Technical or Business School(s) attended:

_____

Diploma(s)/Degree(s)/Certificate(s) achieved: _____

Further Study Plans: _____

OCCUPATIONAL INFORMATION:

Employment status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Retired
☐ Receive Disability ☐ Other: _____

Place of employment: _____ Length of Employment: _____

Position/title: _____ Salary: _____

List of jobs or previous careers: _____

_____

FAMILY INFORMATION

Relationship Status: ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced
☐ Widow(er) ☐ Committed Partnership Date of Same: _____

Name of Spouse/Partner: _____

Previous Marriage(s): State length of the previous marriage(s) and if they ended by divorce or death and when:

_____

Parents: *Mother*: ☐ Living (age ____) ☐ Deceased (date _____)
Father: ☐ Living (age ____) ☐ Deceased (date _____)
Siblings: Number of *Brothers* [____] Number of *Sisters* [____] ☐ Only Child
List ages of *Brothers* _____ of *Sisters* _____

Children: Please list Name(s), Age(s), Sex, By Present Marriage (P), Former Marriage (F), Adopted (A) and whether they live at home.

1. _____

2. _____

3. _____

4. _____

Others who live with you: _____

Any children deceased? _____ If so, how and when? _____

Was your parents' marriage: ☐ Happy ☐ Average ☐ Unhappy

Was your home impacted by: ☐ Separation ☐ Divorce ☐ Death ☐ Other: _____

If yes, how old were you? _____ With whom did you subsequently live? _____

RELIGIOUS INFORMATION:

Do you consider yourself a religious/spiritual person? ☐ Yes ☐ No

Religious preference: _____

Religious background of family: _____

Your congregation: _____

Name of religious leader: _____

Has there been a noticeable or significant change in your spiritual life recently? Describe: _____

_____

_____

HEALTH:

Name, Address & Phone Number of current Primary Care Physician (PCP): _____

_____

Would you like coordinated treatment planning with provider? ☐ Yes ☐ No *Release Required

List any health issues/ illness(s)/ disabilities/ allergies: _____

_____

Surgeries/ Accidents (include dates): _____

_____

Were you ever hospitalized (include #times)? _____ At what age(s)? _____

How long? _____ Reason: _____

Current Medications:

Medication Name	*Dosage*	*Frequency*	*Start Date*	*Prescribing Physician*

What is your alcohol use on average?
☐ None ☐ Less than 1-2x week ☐ 3-5x week ☐ 6-7x week

What is your cannabis/drug use on average?
☐ None ☐ Less than 1-2x week ☐ 3-5x week ☐ 6-7x week

What is your pornography use on average?
☐ None ☐ Less than 1-2x week ☐ 3-5x week ☐ 6-7x week

Have you ever received psychotherapy, counseling or other treatment for personal and/or marital problems?_____ When? _____ Concerns explored were: _____

_____

Name, Address & Phone Number of Mental Health Professional consulted: _____

_____

IMPORTANT QUESTIONS FOR YOU AND YOUR THERAPIST

Please described your reasons for seeking help & how do you think therapy could be helpful?

_____

_____

_____

How long have you been aware of this problem? _____

Who else knows about your problem(s)? _____

If you are seeking family/couples therapy, do you think your family member/partner would answer these questions differently? _____ If so, how? _____

_____

My greatest fear is: _____

My greatest hope is: _____

Please check any areas in which you have concerns or that you feel apply to you:

☐ Anxiety	☐ Elevated mood	☐ Judgment errors	☐ Regrets
☐ Anger	☐ Empty feelings	☐ Lonely	☐ Relationship problems
☐ Alcohol/Substance Use	☐ Fatigue	☐ Loss of faith	☐ Self-esteem problems
☐ Bored	☐ Financial problems	☐ Loss of meaning in life	☐ Sexual addiction
☐ Cannot make decisions	☐ Grief	☐ Misunderstood	☐ Sexual difficulties
☐ Childhood abuse	☐ Guilt	☐ Mood swings	☐ Sleep problems
☐ Confused	☐ Headaches	☐ Muscle tension	☐ Suicidal/ Self-Harm thoughts
☐ Controlling	☐ Hopelessness	☐ Nightmares	☐ Trauma history
☐ Depressed	☐ Identity issues	☐ Pain	☐ Worry
☐ Distractible	☐ Impulsivity	☐ Panic attacks	☐ Other:
☐ Disturbing thoughts	☐ Internet addiction	☐ Phobias/fears	
☐ Eating problems	☐ Irritable	☐ Poor concentration	