



INDIVIDUAL INTAKE FORM

Full Name: _____ D.O.B. _____ Male Female

Preferred Name: _____ Age: _____

Address: _____

City _____ State _____ Zip _____

Primary Phone: _____ Secondary Phone: _____
 Home Work Cell Home Work Cell

E-mail address: _____

I. PERSONAL HISTORY

Education: highest grade level completed _____

Present occupation: _____ How long? _____

Name of church you attend: _____

Referred to Response Care Center by: _____

II. FAMILY HISTORY

Are you currently married? Yes No

Spouse's name: _____ Age: _____

List your marriage(s):

Length of Courtship: _____ **Date Married:** _____ **Date Ended:** _____ **Reason:** (divorce, death, other)

List other immediate family members:

Name	D.O.B.	Relationship to you (specify stepchildren)	Check if at home
_____	_____	_____	<input type="radio"/>
_____	_____	_____	<input type="radio"/>
_____	_____	_____	<input type="radio"/>
_____	_____	_____	<input type="radio"/>
_____	_____	_____	<input type="radio"/>

III. SUBSTANCE USE HISTORY

How often do you use alcohol? Daily Weekly Sometimes Never

How often do you use drugs? Daily Weekly Sometimes Never

In your opinion, has your use of alcohol/drugs ever created a problem for you in regards to:

- | | | |
|---|-------------------------------|--------------------------------|
| <input type="radio"/> Your Wife/Husband | <input type="radio"/> Parent | <input type="radio"/> Law |
| <input type="radio"/> Driving | <input type="radio"/> Job | <input type="radio"/> Children |
| <input type="radio"/> Health | <input type="radio"/> Friends | <input type="radio"/> Finances |

If so, how? _____

IV. COUNSELING HISTORY

Have you had previous counseling? Yes No

If yes, please specify:

Name of Agency/Therapist:	Dates Started/Finished	Type of Counseling:
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_____	_____	_____
_____	_____	_____
_____	_____	_____

V. REASON FOR SEEKING COUNSELING

What are the main issues you are concerned with?

How long have these issues been a concern?

In your opinion, what are the causes of these concerns?

What have you tried to do about these concerns?

If anyone important to you or your family has died, please identify relationship and date of death:

VI. SYMPTOM CHECKLIST

CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

Past	Present		Past	Present	
<input type="radio"/>	<input type="radio"/>	Always tired	<input type="radio"/>	<input type="radio"/>	Crying spells
<input type="radio"/>	<input type="radio"/>	Poor appetite	<input type="radio"/>	<input type="radio"/>	Unable to have fun
<input type="radio"/>	<input type="radio"/>	Trouble sleeping	<input type="radio"/>	<input type="radio"/>	Lacking in confidence
<input type="radio"/>	<input type="radio"/>	Weight gain	<input type="radio"/>	<input type="radio"/>	Feeling grouchy
<input type="radio"/>	<input type="radio"/>	Lack of energy	<input type="radio"/>	<input type="radio"/>	Depressed
<input type="radio"/>	<input type="radio"/>	Fast heartbeat	<input type="radio"/>	<input type="radio"/>	Feeling lonely
<input type="radio"/>	<input type="radio"/>	Frequent sweating	<input type="radio"/>	<input type="radio"/>	Not enjoying things
<input type="radio"/>	<input type="radio"/>	Dizziness	<input type="radio"/>	<input type="radio"/>	Suicidal thoughts
<input type="radio"/>	<input type="radio"/>	Shaky hands	<input type="radio"/>	<input type="radio"/>	Feeling inferior
<input type="radio"/>	<input type="radio"/>	Stomach trouble	<input type="radio"/>	<input type="radio"/>	Loss of sexual interest
<input type="radio"/>	<input type="radio"/>	Feeling tense	<input type="radio"/>	<input type="radio"/>	No one understands me
<input type="radio"/>	<input type="radio"/>	Cold feet and hands	<input type="radio"/>	<input type="radio"/>	Worried about health
<input type="radio"/>	<input type="radio"/>	Diarrhea	<input type="radio"/>	<input type="radio"/>	Can't concentrate
<input type="radio"/>	<input type="radio"/>	Constipation	<input type="radio"/>	<input type="radio"/>	Can't get going
<input type="radio"/>	<input type="radio"/>	Muscle twitching/jumping	<input type="radio"/>	<input type="radio"/>	Feeling angry
<input type="radio"/>	<input type="radio"/>	Nausea or vomiting	<input type="radio"/>	<input type="radio"/>	Don't like being alone
<input type="radio"/>	<input type="radio"/>	Headaches	<input type="radio"/>	<input type="radio"/>	Always worried
<input type="radio"/>	<input type="radio"/>	Fainting spells	<input type="radio"/>	<input type="radio"/>	Nightmares
<input type="radio"/>	<input type="radio"/>	Poor physical health	<input type="radio"/>	<input type="radio"/>	Feeling panicky
<input type="radio"/>	<input type="radio"/>	Full of energy	<input type="radio"/>	<input type="radio"/>	Can't make decisions
<input type="radio"/>	<input type="radio"/>	Binging	<input type="radio"/>	<input type="radio"/>	Can't make friends
<input type="radio"/>	<input type="radio"/>	Purging	<input type="radio"/>	<input type="radio"/>	Unable to relax
<input type="radio"/>	<input type="radio"/>	Excessive dieting	<input type="radio"/>	<input type="radio"/>	Feeling fearful
<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	Overly sensitive
<input type="radio"/>	<input type="radio"/>	Financial problems	<input type="radio"/>	<input type="radio"/>	Anxious inside
<input type="radio"/>	<input type="radio"/>	Marital problems	<input type="radio"/>	<input type="radio"/>	Easily excitable
<input type="radio"/>	<input type="radio"/>	Difficulties at work	<input type="radio"/>	<input type="radio"/>	Quick tempered
<input type="radio"/>	<input type="radio"/>	Excessive drinking	<input type="radio"/>	<input type="radio"/>	Excessive use of medication
<input type="radio"/>	<input type="radio"/>	Can't hold a job	<input type="radio"/>	<input type="radio"/>	Impatient with people
<input type="radio"/>	<input type="radio"/>	Excessive use of drugs	<input type="radio"/>	<input type="radio"/>	Easily angered
<input type="radio"/>	<input type="radio"/>	Problems with children	<input type="radio"/>	<input type="radio"/>	Very restless
<input type="radio"/>	<input type="radio"/>	Problems with parents	<input type="radio"/>	<input type="radio"/>	Feel like hurting someone
<input type="radio"/>	<input type="radio"/>	Fighting and quarreling	<input type="radio"/>	<input type="radio"/>	Feel like smashing things
<input type="radio"/>	<input type="radio"/>	Can't handle money	<input type="radio"/>	<input type="radio"/>	Gay issues
<input type="radio"/>	<input type="radio"/>	Overly ambitious	<input type="radio"/>	<input type="radio"/>	Shy with people
<input type="radio"/>	<input type="radio"/>	Difficulties at school	<input type="radio"/>	<input type="radio"/>	Sexual abuse issues
<input type="radio"/>	<input type="radio"/>	Difficulties with the law	<input type="radio"/>	<input type="radio"/>	Abortion issues
<input type="radio"/>	<input type="radio"/>	Untruthfulness			
<input type="radio"/>	<input type="radio"/>	Loss of meaning of life	<input type="radio"/>	<input type="radio"/>	Feeling guilty
<input type="radio"/>	<input type="radio"/>	Unable to pray	<input type="radio"/>	<input type="radio"/>	Unable to experience forgiveness
<input type="radio"/>	<input type="radio"/>	Unresolved grief	<input type="radio"/>	<input type="radio"/>	Lacking a sense of peace
<input type="radio"/>	<input type="radio"/>	Confused about personal religious practice			

Completed by: Self Parent /Legal Guardian Other, specify: _____

Your Signature _____ Date: _____



STATEMENT OF CONFIDENTIALITY AND CONSENT TO PASTORAL COUNSELING

At Response Care Center (RCC), one of our highest priorities is to be a ministry you can trust. To assist in the development of an atmosphere of trust, we want you to understand the extent and limitations of confidentiality. Please sign this document and return prior to your first counseling appointment.

- 1. Everything said by you and to you in the counseling relationship (as well as any testing or assessment) is kept in the strictest confidence. Nothing will be communicated to anyone outside of RCC staff either verbally or in writing unless you (or a legal guardian if you are minor) sign an official release form. This form will specify: a) exactly what information will be released; b) to whom; c) for what purpose; and d) the length of time a the release will be effective.
- 2. Session summaries are the responsibilities of the RCC Director and are kept under lock and key (all notes will be destroyed one year after termination).
- 3. From time to time, your case may be discussed with specific RCC staff, interns, or team members for purposes of case planning and/or consultation. No information, however, may go any further than this relationship.
- 4. Confidentiality will be broken in the following specific situations:
 - a. If there is a reason to believe you may be a physical threat to your own safety or well being.
 - b. If there is reason to believe that you could be physically harmful to another person. In such cases all appropriate people will be notified, including the police and person(s) at risk.
 - c. If there is "reason to suspect a child is in danger of non-accidental physical or mental injury, sexual abuse, or is living in a seriously damaging home environment due to ... inappropriate child rearing practices." By law, we must report this to the Protective Services unit of the local County Department of Social Services.
 - d. When there is the intention of criminal acts or the expressed intention of committing criminal acts.

I FULLY UNDERSTAND THE EXTENT AND LIMITATIONS OF CONFIDENTIALITY AND VERIFY MY UNDERSTANDING BY MY SIGNATURE BELOW.

I, _____, certify that I understand that the services I receive at the Response Care Center are based on biblical principles. I agree to cooperate in pastoral counseling and/ or assessment to my fullest ability. I reserve the right to terminate pastoral counseling at any time. However, I will discuss this decision with my counselor before discontinuing services. I understand it is my responsibility to give a 24-hour notice to cancel any scheduled appointment.

I understand that the results of pastoral counseling/assessment cannot be warranted or guaranteed.

_____ (Your name, printed)

_____ (Your name, signed)

_____ (Signature of parent or guardian, if under 18)

_____ (Relationship of signer to minor)

_____ (Signature of RCC staff member)

_____ (Date)