CLIENT INTAKE FORM

Client Reference # _____ Mail form to: _____
Date: _____ Would you like to receive our newsletter?_____
Name (please print): _____ Cell Phone: (___)_____
Address: _____ Home Phone: (___)_____
City: _____County_____ Work Phone: (___)_____
State: _____Zip: _____ Email: _____May we contact you at home? Yes / No
When is a good time to contact you? _____ Leave a message? Yes / No Texting? Yes / No
Emergency Contact Person:_____Phone #:_____

Check appropriate boxes

AGE	FAMILY STATUS	CHILDREN	AVAILABLE FOR COUNSELING DAY	TIME
☐ Under 20	☐ Married	☐ Living at home	☐ M	_____ to _____
☐ 20-29	☐ Single	☐ Grown; living elsewhere	☐ T	_____ to _____
☐ 30-39	☐ Divorced	☐ Other (please explain)	☐ W	_____ to _____
☐ 40-49	☐ Separated	_____	☐ Th	_____ to _____
☐ 50-59	☐ Widowed	_____	☐ F	_____ to _____
☐ 60+				

TYPES OF CRISIS

☐ abuse - sexual	☐ depression	☐ spouse	☐ promiscuity	☐ spirituality
☐ abuse - physical	☐ divorce	☐ illness/disability	☐ relationships	☐ suicide
☐ alcohol/drugs	☐ eating disorders	☐ jail	☐ self-esteem	☐ woundedness from childhood
☐ childlessness	☐ fears/phobias	☐ parenting	☐ sexuality	
☐ death	☐ financial	☐ pregnancy	☐ singleness	

*If possible, please prioritize your crises (1, 2, 3, etc.). What issue is most pressing at this time? _____
Are you employed outside the home? _____ Where? _____
Church affiliation: _____
How did you find out about this ministry? Newspaper: _____Radio: _____Brochure: _____ Church: _____
Friend: _____ Professional referral: _____ Website: _____ Social Media: _____ Other:_____
Please name the referral:_____
Have you had counseling before? _____ Where? _____
Please list any medications you are currently taking. _____
_____
Do you have any medical conditions that your peer counseling volunteer should be aware of as you come for counseling? (i.e. seizures, diabetes, allergies) Please list. _____
_____

Thank you for being here. Your presence here is a confirmation that this ministry is needed.
It is our prayer that you will receive a measure of peace about your situation as you share your story with one of our counseling volunteers. We want you to feel comfortable as you share with this partner, knowing that anything you say will be held in confidence. We have made every effort to connect you with someone who has been through a similar situation as you have, and has experienced healing through Christ.

Our counseling volunteers are not professionals and should not be a substitute for professional psychological, psychiatric or medical care. We are here to share with you and support you with scripture and prayer.
Please sign here indicating you have read the above and realize our limitations:

Signed: _____

Please summarize the need that brings you here, continue on back if necessary.
_____
If you could use only one word to describe your feelings about your situation at this point, what would it be?
_____