OASIS CHRISTIAN COUNSELING

INTAKE FORM – BIOGRAPHICAL INFORMATION

Please fill out this biographical information form as completely as possible and bring it with you to your first session. Information is confidential as outlined in the Office Policy form and the HIPAA Notice of Privacy Practices. If you do not desire to answer any question, merely write "Do not care to answer."

NAME_____M/F_____DATE_____

DATE AND PLACE OF BIRTH_____AGE_____

ADDRESS_____

PHONE H_____C_____W_____

EMAIL_____PREFERRED NUMBER FOR MESSAGES H / C / W

PERSON AND PHONE # TO CALL IN EMERGENCY_____

REFERRAL SOURCE_____

HIGHEST GRADE/DEGREE_____TYPE OF DEGREE_____

OCCUPATION (FORMER, IF RETIRED) _____

PRESENTING PROBLEM (be as specific as you can: when did it start, how does it affect you) _____

_____

_____

Estimate the severity of above problem: Mild_____Moderate____Severe_____Very severe____

MARITAL STATUS_____ LIVE WITH SOMEONE___Name:_____#of Years____

PAST & PRESENT MARRIAGES: names, years together and statement about the nature of the relationships, i.e. friendly, distant, physically/emotionally abusive, loving, hostile)

_____

_____

_____

_____

PRESENT SPOUSE/PARTNER: Education _____

Occupation _____

CHILDREN/STEP/GRAND (names/ages & brief statement on your relationship with the person)

1. _____
2. _____
3. _____

PARENTS/STEPPARENTS (Name/age or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship):

Father_____

_____

_____

Mother_____

_____

_____

Stepparents _____

_____

_____

SIBLINGS (name/age, if deceased: age and cause of death and brief statement about the relationship)

1. _____
2. _____
3. _____

DESCRIBE YOUR CHILDHOOD IN GENERAL _____

_____

_____

DO YOU ATTEND A CHURCH OR OTHER PLACE OF WORSHIP? _____

IF YES, NAME _____

DESRCIBE YOUR CURRENT FRIENDSHIPS _____

DESCRIBE ANY COMMUNITY INVOLVEMENT _____

MEDICAL DOCTOR (name/phone) _____

_____

MEDICAL HISTORY (major medical problems, surgeries, accidents, falls, illness, etc) _____

_____

_____

_____

LIST ALL CURRENT MEDICATIONS (include dosages and reason for taking) _____

_____

FAMILY MEDICAL HISTORY (Describe any illness that runs in the family e.g. cancer, epilepsy) _____

_____

_____

DO YOU SMOKE? ___ IF YES, AMOUNT/FREQUENCY_____

DO YOU DRINK ALCOHOL? __ IF YES, AMOUNT/FREQUENCY _____

PAST/PRESENT DRUG/ALCOHOL TREATMENT (AA. NA, rehab) _____

_____

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS OR VIOLENCE (including suicide depression, hospitalizations in mental institutions, abuse, etc)

_____

_____

SUICIDE ATTEMPTS OR VIOLENT BEHAVIOR (describe ages, reasons, circumstances, how, etc)

_____

_____

PAST/PRESENT PSYCHOTHERAPY (specify:month/year (beginning-end), estimated number of sessions, name and address of therapist, initial reason for therapy, indiv/couple/family, medication, brief description of the relationship and how helpful it was, and how/why it ended

_____

_____

_____

_____

ARE YOU INVOLVED IN ANY CURENT OR PENDING CIVIL OR CRIMINAL LITIGATIONS, LAWSUITS, DIVORCE OR CUSTODY DISPUTES (If yes, please explain) _____

_____

_____

WHAT GIVES YOU THE MOST JOY OR PLEASURE IN YOUR LIFE? _____

_____

WHAT ARE YOUR MAIN WORRIES AND FEARS? _____

_____

WHAT ARE YOUR MOST IMPORTANT HOPES OR DREAMS? _____

_____

THANK YOU!