Conway Biblical Counseling Center

INTAKE FORM

Taking the first step to ask for help is really hard. We are thankful you are taking that first step! This intake will help us understand you and your situation better.

Name: Birthdate:

Address (incl. city):

Best number to contact you: Is it safe to leave a message? ❑ Yes ❑ No

Second best number to contact you: Is it safe to leave a message? ❑ Yes ❑ No

Email:

Sex: ❑ Male ❑ Female

Occupation:

Current church attending, if any:

❑ Single ❑ Married ❑ Remarried ❑ Widowed ❑ Divorced ❑ Other:

If applicable, spouse's name: Length of relationship:

Will your spouse be attending the counseling with you? ❑ Yes ❑ No

Are you receiving help aside from our counseling center? ❑ Yes ❑ No

If yes, please briefly share who or what organization:

Have you been to our counseling center before? ❑ Yes ❑ No

If yes, when (year)? Under what name? ❑ Same

How did you hear about our center? ❑ Church ❑ Friend ❑ Ad ❑ Other:

Your answers to the following will help make clear your reasons for coming for counseling and allows us to learn important information about you.

1. *For what problems or concerns are you seeking help?*

2. *What have you done about these issues? Have you sought support from anyone? Are you using coping strategies like self-harm, over-eating or under-eating, drinking, etc.?*

3. *What would be your goal with regard to the problems or concerns you listed in question 1?*

4. *What prompted you to seek counseling at this time?*

5. Assign a number from 1 to 5 how motivated you are to change. 1 would be very little and 5 would be very much.

6. *Please refer to the Biblical Counseling Agreement" document and review the section "client responsibilities." Are you willing and able to meet these expectations?* ❑ Yes ❑ No

7. *What would be helpful for your counselor to know about you? (E.g. learning disability, need to figure out transportation, have a physical disability, etc.)*

8. *a) Are you currently seeing another counselor or mental health professional?* ❑ Yes ❑ No
   b) Have you seen a counselor or mental health professional in the past? ❑ Yes ❑ No

9. a) *Have you received a mental health diagnosis?* ❑ Yes ❑ No
   b) *If you answered yes, what diagnosis have you received?*

10. a) *Are you taking any medications?* ❑ Yes ❑ No
    b) *If you answered yes, which medications and what are they for?*
    c) *How long have you been taking each medication?*

11. a) *Do you drink alcohol?* ❑ Yes ❑ No ❑ In the past
    b) *Do you smoke tobacco or use marijuana?* ❑ Yes ❑ No ❑ In the past
    If marijuana, for which purpose? ❑ Medical ❑ Recreational
    c) *Do you use illegal drug(s)?* ❑ Yes ❑ No ❑ In the past
    If yes or in the past, what drug(s)?

    d) *If you answered yes to 11 a, b, or c, how frequently do you use?*
    ❑ Once or twice a week ❑ Daily ❑ Multiple times a day ❑ Occasionally

    e) *Do other people say that you have a problem with drinking or using? Do you think you have a problem with your drinking or using? Explain your answer about yourself.*

12. a) *Do you currently experience suicidal thoughts, feelings, or actions?* ❑ Yes ❑ No
    b) *If yes, have you thought of a plan how to do this?* ❑ Yes ❑ No
    c) *Have you had such thoughts in the past? If yes, how long ago?* ❑ Yes ❑ No

13. a) *Do you have any current thoughts or feelings about harming others?* ❑ Yes ❑ No
    b) *Were you ever arrested, charged, or incarcerated for assault or abuse?* ❑ Yes ❑ No

    c) *If you answered "yes," please share below the date(s) and charges:*

14. *What significant events or losses have you experienced (e.g. death of someone close, abuse (emotional/verbal, physical, sexual), bankruptcy, abortion, miscarriage/infant loss, divorce, etc.?*

15. What significant life events or changes are you anticipating in the near or distant future? (e.g. illness, divorce, custody issues, job loss, death of someone close, marriage, etc.)?

16. a) *Do you have concerns in any of the following areas that were not mentioned above? Check all that apply.*

❑ marriage	❑ eating disorders	❑ being single
❑ money/budgeting	❑ sexuality/sexual identity	❑ sexual intimacy
❑ children	❑ child custody	❑ parents
❑ in-laws	❑ family	❑ church/ministry
❑ work/career	❑ school/learning	❑ aging/dependency

❑ disability	❑ chronic pain	❑ loneliness
❑ depression	❑ codependency	❑ communication
❑ current abuse	❑ pornography	❑ other addictions
❑ anger control	❑ stress control	❑ fear/anxiety
❑ mood swings	❑ self image	❑ God/faith

b) *Please share any details about your answers to 16a that might help us understand you better.*

17. *What is your religious background if any?*

18. *If you currently identify as a Christian, describe what that means to you?*

19. *In what ways do you practice your faith/religion?*

20. *If you have spiritual leaders, do you want them involved in the counseling process?* ❑ Yes ❑ No
If yes, please provide their name(s) and contact information below.

Once you have completed this Intake Form and the Biblical Counseling Agreement form, please email them to ConwayBiblicalCounseling@gmail.com or you may mail it to:

Conway Biblical Counseling Center
7 Lake Street
Greenbrier, AR 72058-9221

Once we receive your completed form, it will take a few days to process it and set an appointment date.