



# HOMETOWN PASTORAL COUNSELING GROUP PLC

## INTAKE FORM

Date: \_\_\_/\_\_\_/\_\_\_

Pastoral Counselor: \_\_\_\_\_

## PERSONAL INFORMATION

Name: \_\_\_\_\_

US Citizen?  Yes  No

Address: \_\_\_\_\_

If no, immigration status: \_\_\_\_\_

City: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

County: \_\_\_\_\_

Sex:  Female  Male  Unknown

Home Phone: (\_\_\_\_) \_\_\_\_\_

Night Phone: (\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_

Okay to leave message?  Yes  No

Okay to leave message?  Yes  No

Email Address: \_\_\_\_\_

Okay to text?  Yes  No

\_\_\_\_\_

### SEXUAL ORIENTATION

### ETHNICITY

### LEVEL OF EDUCATION

Heterosexual

American Indian/Alaskan Native

None

Gay

Asian American

Elementary School

Lesbian

Black/African American

Middle School

Bisexual

Hispanic

High School

Transgender

Multiracial

GED

Other

Pacific Islander

Vocational Training

Unknown

White

Some College

Other

College Degree

Unknown

Graduate/Ph.D.

## RELATIONSHIP STATUS      RELATIONSHIP HISTORY

Legally Married Length: \_\_\_\_\_

Separated Length: \_\_\_\_\_

Who does the client live with? \_\_\_\_\_

Children's names and ages: \_\_\_\_\_

**GENOGRAM**

(For Office Use Only, if Unknown)

**PRESENTING PROBLEM/ CONCERN/SPIRITUAL STRUGGLES**

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**CURRENT EMPLOYMENT**

Where: \_\_\_\_\_

Position: \_\_\_\_\_ Annual Household Gross Salary (*Inclusive of all self and spouse sources of income, such as: child support, pensions, stocks/dividends, etc*):

\_\_\_\_\_

If unemployed, why? \_\_\_\_\_

**CURRENTLY ON PROBATION/PAROLE**

\_\_\_ YES, Officer's Name: \_\_\_\_\_

Charged with: \_\_\_\_\_

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**COUNSELING HISTORY/FAMILY HISTORY OF COUNSELING**

Previous history of mental health/pastoral counseling?  Yes  No  
If yes, details: When \_\_\_\_/\_\_\_\_  
Counselor: \_\_\_\_\_  
Treated for: \_\_\_\_\_  
\_\_\_\_\_  
Family History of Counseling?  Yes  No  
If yes, details: When \_\_\_\_/\_\_\_\_  
Counselor: \_\_\_\_\_  
Treated for: \_\_\_\_\_  
\_\_\_\_\_

**PENDING COURT CASE**

Yes  No  
If yes, details: \_\_\_\_\_  
\_\_\_\_\_

**SUBSTANCE ABUSE**

Recovering Alcoholic?  Yes  No                      Family History?  Yes  No  
Recovering Drug Addict?  Yes  No                      Family History?  Yes  No  
Caffeine?  Yes  No    Frequency: \_\_\_\_\_  
Tobacco?  Yes  No    Frequency: \_\_\_\_\_  
Alcohol?  Yes  No    Frequency: \_\_\_\_\_  
Drugs?  Yes  No    Frequency: \_\_\_\_\_  
Other details: \_\_\_\_\_  
\_\_\_\_\_  
Previous treatment for drug/alcohol abuse?  Yes  No  
If yes, details: When \_\_\_\_/\_\_\_\_  
Treatment facility: \_\_\_\_\_  
Other information: \_\_\_\_\_  
\_\_\_\_\_  
Needle use?  Yes  No  
HIV test?  Yes  No    Date: \_\_\_\_/\_\_\_\_    Results: \_\_\_\_\_  
Hepatitis test?  Yes  No    Date: \_\_\_\_/\_\_\_\_    Results: \_\_\_\_\_

**MEDICAL HISTORY**

Current medical treatment?  Yes  No

If yes, details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physical conditions/diagnoses: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Doctor's Name and Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Current Medications and Dosages: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Past Medications for Mental Disorders: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Childhood Illnesses and/or Injuries: \_\_\_\_\_  
\_\_\_\_\_

Head Injuries: \_\_\_\_\_  
\_\_\_\_\_

Hospitalizations: \_\_\_\_\_  
\_\_\_\_\_

### ABUSIVE EXPERIENCES

Client reported being sexually abused as a child.  Yes  No

Client's parents were abusive to each other.  Yes  No

Client's parents were abusive to their children.  Yes  No

Client's siblings were abusive to each other.  Yes  No

Client's siblings were abusive to their parents.  Yes  No

Client reports currently being abusive.  Yes  No

Client reports currently being abused.  Yes  No

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### SEXUAL HISTORY/CURRENT ABUSE

Most Recent:

Worst Incident:

First Incident:

**SUICIDAL AND/OR HOMICIDAL IDEATION**

Current suicidal thoughts/attempts: \_\_\_ Yes \_\_\_ No

Past suicidal thoughts/attempts: \_\_\_ Yes \_\_\_ No

Details: \_\_\_\_\_  
\_\_\_\_\_

Current homicidal thoughts/attempts: \_\_\_ Yes \_\_\_ No

Past homicidal thoughts/attempts: \_\_\_ Yes \_\_\_ No

Details: \_\_\_\_\_  
\_\_\_\_\_

**GOALS**

Preferred Appointment Time: \_\_\_\_\_

Client given a copy of Disclosure Statement. \_\_\_ Yes \_\_\_ No

Language Needs. \_\_\_ Yes \_\_\_ No

Religious Preferences: \_\_\_\_\_

Denomination/Faith: \_\_\_\_\_ Local Church: \_\_\_\_\_

Emergency Contact: **(REQUIRED)** \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Client would like counselor to inform listed physician that they are receiving counseling services at Hometown Pastoral Counseling Group. \_\_\_ Yes \_\_\_ No If yes is marked a separate authorization form must be signed by the client.

Who referred you to HTPCG? \_\_\_\_\_ Relationship: \_\_\_\_\_

Client deemed inappropriate for this facility/agency. \_\_\_ Yes \_\_\_ No

Counselor Notes: \_\_\_\_\_  
\_\_\_\_\_

Counselor Signature: \_\_\_\_\_ Date: \_\_\_\_\_