# 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

☐ Legally Married Length:_____

☐ Separated Length:_____

## RELATIONSHIP HISTORY

_____

_____

Who does the client live with? _____

Children's names and ages: _____



Revised 2/21/22

## GENOGRAM

(For Office Use Only, if Unknown)

## PRESENTING PROBLEM OR CONCERN

_____

_____

_____

_____

_____

_____

_____

_____

_____

## CURRENT EMPLOYMENT

Where:_____

Position: _____ Annual Household Gross Salary (***Inclusive of all* sources*: such as child support, pensions, stocks/dividends, etc***): _____

If unemployed, why? _____

## CURRENTLY ON PROBATION/PAROLE

___ YES, Officer's Name:_____

Charged with:_____

_____

_____

_____

_____

_____

## 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 incident: _____

_____

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

## CLINICAL IMPRESSIONS/OBSERVATIONS

## MISC. NOTES

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: _____