



## INTAKE/PERSONAL HISTORY

Reminders as you come in for your first appointment:

- Please **complete this paperwork** and bring it to your first appointment. If you are unable to complete this paperwork prior to your appointment, please arrive at least 15 minutes early to finish it. The disclosure statement must be signed and dated before being seen for counseling.
- If you need to **change or cancel any appointments**, please contact our administrative assistant, Amy Hashbarger @ 701.232.4476 or [amyhashbarger@bethelc.com](mailto:amyhashbarger@bethelc.com) as soon as possible. We have a 24-hour cancellation policy.
- **In the event of Winter Weather/Storms:** We follow the Fargo Public School System's Winter Weather Announcements. If they are closed, so are we. If they open late, so do we. If they close early, so do we. In the event of a weather announcement affecting your appointment, someone from our office will contact you regarding rescheduling as soon as we are back in the office.
- Bethel Church Counseling is a free service because of our generous donors. **A \$20 non-deductible, cost sharing donation per visit is suggested.**

## INTAKE/PERSONAL HISTORY

### CLIENT INFORMATION:

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender M/F Age: \_\_\_\_\_

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

Cell Phone: \_\_\_\_\_

Is it okay to leave a message for you at this number?  Y  N

Home Phone: \_\_\_\_\_

Is it okay to leave a message for you at this number?  Y  N

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

Is it okay to email you at this account?  Y  N

How did you hear about us? \_\_\_\_\_

### EMERGENCY CONTACT:

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

Phone Number: \_\_\_\_\_

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

### MARITAL STATUS:

Single  Married If married, how long? \_\_\_\_\_

Previously married -- How many times? \_\_\_\_\_  Separated -- How long? \_\_\_\_\_

Living with someone -- How long? \_\_\_\_\_  Widowed -- How long? \_\_\_\_\_

List the names of your children and their ages:

\_\_\_\_\_  
\_\_\_\_\_

**EDUCATIONAL HISTORY:**

Years completed \_\_\_\_\_

Problems: \_\_\_\_\_

\_\_\_\_\_

Strengths: \_\_\_\_\_

\_\_\_\_\_

**WORK HISTORY:**

Usual occupation: \_\_\_\_\_

Are you currently employed:  Yes  No Length of time: \_\_\_\_\_

If you have changed jobs during the last five years, give duration of employment and reason for leaving job:

\_\_\_\_\_

**Please describe the problem(s) that you want help with:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

How has this problem affected your life in the following areas?

1. Family \_\_\_\_\_

2. Work \_\_\_\_\_

3. Social \_\_\_\_\_

4. Recreational \_\_\_\_\_

5. Health \_\_\_\_\_

Please list any important events in your life that may relate to this problem:

---

---

---

How serious is this problem?

Mild

Moderate

Very

Extreme

Total

What have you tried to do to solve this problem?

---

---

---

What has been successful?

---

---

---

Have you had counseling/therapy in the past?  Y  N

If so, where? \_\_\_\_\_ When? \_\_\_\_\_

What was helpful about the counseling?

---

---

What was not helpful about the counseling?

---

---

What are you hoping to achieve through counseling?

---

---

**PHYSICAL AND MENTAL HEALTH:**

How would you rate your current health?

Very poor 1    2    3    4    5    6    7    8    9    10    Very good

List current health problems for which you are receiving treatment:

---

List any medications currently prescribed:

---

What is your current use of alcohol?

---

Have you had problems with alcohol use in the past?     Y     N

If yes, please explain:

---

What is your current use of other drugs?

---

Have you been arrested for alcohol/drug related offenses?     Y     N

Have you had treatment for problems with alcohol abuse/dependency?     Y     N

Do you have a history of drug use?     Y     N

Have you had treatment for drug abuse/dependency?     Y     N

Have you ever lost a job/relationship due to the use of alcohol/drugs?     Y     N

Indicate any of the following that apply to you:

Current

Past

_____	_____	Thoughts of suicide
_____	_____	Plan for suicide
_____	_____	Suicide attempt
_____	_____	Hurting yourself deliberately
_____	_____	Thoughts of hurting someone else

Have you suffered from a brain injury?

Y  N

If Yes, please explain:

---

**FAMILY HISTORY:**

Who raised you? \_\_\_\_\_

If there were changes, please list and indicate the age you were when these changes occurred:

---

# of siblings \_\_\_\_\_ # brothers \_\_\_\_\_ # sisters \_\_\_\_\_

In rank order from oldest to youngest, what is your place in the order? \_\_\_\_\_

Which members of your family are you close to?

---

Are there any family members who are a problem for you?

---

Please indicate other people in your life that provide support for you:

---

**Please check any problems that family members have/have had and indicate relationship:**

	<u>Relationship</u>		<u>Relationship</u>
<input type="checkbox"/> Arrests/convictions	_____	<input type="checkbox"/> Depression	_____
<input type="checkbox"/> Alcoholism	_____	<input type="checkbox"/> Violence	_____
<input type="checkbox"/> Other mental/emotional problems (list below)			

---

**Check any of the following that apply to your childhood/adolescence:**

- Happy childhood   
  School problems   
  Medical problems   
  Unhappy childhood  
 Family problems   
  Alcohol use   
  Drug use   
  Arrests/convictions  
 Death of close family member

If so, who? How old were you when they passed away?

---

<b>Victim of:</b>	<b>Current</b>	<b>Past</b>		<b>Current</b>	<b>Past</b>
Sexual Abuse	_____	_____	Physical Abuse	_____	_____
Domestic Violence	_____	_____	Emotional Abuse	_____	_____

<b><u>SEVERITY OF PROBLEM:</u></b> 0=NO PROBLEM 5=DISABLING	<b>INDICATE ANY PROBLEMS IN THE FOLLOWING AREAS:</b>	<b>EXPLAIN</b>
0 1 2 3 4 5	Sleep too much	
0 1 2 3 4 5	Sleep too little	
0 1 2 3 4 5	Interrupted sleep	
0 1 2 3 4 5	Other sleep problems	
0 1 2 3 4 5	Memory	
0 1 2 3 4 5	Concentration	
0 1 2 3 4 5	Attention	
0 1 2 3 4 5	Loss of interest in usual activities	
0 1 2 3 4 5	Feelings of sadness	
0 1 2 3 4 5	Loss of energy	
0 1 2 3 4 5	Feeling tired all the time	

0 1 2 3 4 5	Periods of crying
0 1 2 3 4 5	Feeling of hopelessness
0 1 2 3 4 5	Loss of sexual desire
0 1 2 3 4 5	Outbursts of anger
0 1 2 3 4 5	Change in appetite
0 1 2 3 4 5	Hearing voices when no person is present
0 1 2 3 4 5	Unable to recall periods of time in childhood after age 5
0 1 2 3 4 5	Unable to recall some period of your day
0 1 2 3 4 5	Walking in sleep
0 1 2 3 4 5	Nightmares
0 1 2 3 4 5	Overwhelming fears
0 1 2 3 4 5	Racing thoughts
0 1 2 3 4 5	Thoughts that won't go away that are constantly in your head
0 1 2 3 4 5	Thoughts of harming someone else
0 1 2 3 4 5	Thoughts that some person or people are trying to harm you
0 1 2 3 4 5	Noticing items in your home and not knowing where they came from or how they got there
0 1 2 3 4 5	Feelings of being controlled by forces outside yourself
0 1 2 3 4 5	Feeling compelled to repeat activities for no reason
0 1 2 3 4 5	Unable to relax
0 1 2 3 4 5	Blackouts
0 1 2 3 4 5	Excessive sweating



0 1 2 3 4 5	Death of family members or friends
0 1 2 3 4 5	Panic attacks
0 1 2 3 4 5	Mood swings
0 1 2 3 4 5	Spending sprees
0 1 2 3 4 5	Changes in energy level
0 1 2 3 4 5	Other:

**PSYCHOSOCIAL AND ENVIRONMENTAL PROBLEMS**

Please rate each of the following problem areas that have been present during the past year or those occurring prior to one year if they clearly contribute to the reasons for seeking treatment.

Please write in the specific problem:

0=No significant problem

1=Mild or transient problem

2=Moderate

3=severe

4=Extreme

5=Catastrophic

NA=Unknown or cannot categorize

0 1 2 3 4 5 NA **Problems with primary support group:** Death of a family member, separation, divorce, removal from home, sexual or physical abuse, discord in the family with parents, siblings, or other like events.

0 1 2 3 4 5 NA **Problems related to the social environment:** death or loss of a friend, living alone, discrimination, adjustment to life-cycle transitions such as leaving home or retirement.

0 1 2 3 4 5 NA **Educational problems:** Unable to read, academic problems, discord with teachers or classmates.

0 1 2 3 4 5 NA **Occupational problems:** Unemployment, threat of job loss, stressful work schedule, discord with boss or co-workers.

0 1 2 3 4 5 NA **Housing problems:** Homeless, unsafe neighborhood, discord with neighbors or landlord.

0 1 2 3 4 5 NA **Economic problems:** Not enough money to pay bills, food and rent.

0 1 2 3 4 5 NA **Problems with access to health care services:** Inadequate health care, transportation to health care facilities unavailable, inadequate health insurance.

0 1 2 3 4 5 NA **Problems related to interaction with the legal system/crime:** Arrest, incarceration, litigation, victim of a crime.

0 1 2 3 4 5 NA **Other psychosocial and environmental problems:** Exposure to disasters, discord with non-family caregivers such as counselor, social worker or physician, unavailability of social service agencies.

**RELATIONSHIP WITH GOD**

Describe your relationship with God.

---

---

---

If you attend church, where? How often? \_\_\_\_\_

Are you involved in any way at your church? \_\_\_\_\_

Describe your religious upbringing.

---

---

---

Do you have any additional information you would like to share?

---

---

---