

Compassion Counseling Center

Intake Form



Instructions:

- Answer the following questions to the best of your ability.
- Mail the completed form to:
Compassion Counseling Center
5500 25th Ave. NW
Rochester, MN 55901

1. Name: _____ Age: _____ Birth date: _____
First Middle Initial Last mm/dd/yyyy

2. Address: _____ (Circle one) Male Female
Street Address & Apt. #

City State ZIP Code

3. Phone: (_____) _____ Home Cell Work

Can we leave a message at this phone number: Yes No

4. Email: _____

5. How do you prefer to be contacted: Phone Email

6. Person to contact in case of emergency:

Name: _____

Address: _____

Phone: _____ Relationship to you: _____

7. Race:

- | | |
|--|---|
| <input type="checkbox"/> White | <input type="checkbox"/> Pacific Islander |
| <input type="checkbox"/> Black | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Native American | |

8. Education level completed:

- | | |
|---|---|
| <input type="checkbox"/> High School
Last grade completed: _____ | <input type="checkbox"/> Some college |
| <input type="checkbox"/> GED | <input type="checkbox"/> Four Year Degree – Major: _____ |
| <input type="checkbox"/> Junior College | <input type="checkbox"/> Graduate Degree - Subject: _____ |
| <input type="checkbox"/> Vocational School | <input type="checkbox"/> Post-Graduate – Subject: _____ |

9. Current employment status:

- | | |
|---|--|
| <input type="checkbox"/> Employed Full-Time | <input type="checkbox"/> Unemployed |
| <input type="checkbox"/> Employed Part-Time | <input type="checkbox"/> Disability Assistance |
| <input type="checkbox"/> Self-employed | <input type="checkbox"/> Stay Home Parent |
| <input type="checkbox"/> Retired | <input type="checkbox"/> Other: _____ |

10. Marital status:

- | | | |
|---|------------------------------------|------------------------------------|
| <input type="checkbox"/> Single | <input type="checkbox"/> Separated | <input type="checkbox"/> Remarried |
| <input type="checkbox"/> Domestic Partner | <input type="checkbox"/> Divorced | <input type="checkbox"/> Widowed |
| <input type="checkbox"/> Married | | |



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11. Number of children: _____ Ages: ____/____/____/____/____/____/____

12. Who recommended you seek counseling?

- Self-Referred
- Spouse
- Family member
- Friend
- Physician
- Other, please specify: _____

13. What is the main issue you are seeking counseling for?

14. How long have you had symptoms/problems related to the current issue? _____

15. What has prompted you to seek help at this time?

16. What areas of your life are affected by your symptoms/problem? Check all that apply.

- Work
- School
- Marital/Significant Other Relationship
- Other Close Relationships
- Personal Hygiene
- Household Duties
- Social/Leisure Activities
- Other, please specify: _____

17. Have you been diagnosed with any of the following? Check all that apply.

- Addiction of any kind
e.g. gambling, sexual, pornography, alcohol,
drugs/chemicals – street or prescription
Please specify: _____
- Anxiety Disorder
- Autism Spectrum Disorder
- Bipolar Disorder
- Depression
- Eating Disorder
- Impulse Control Disorder
- Learning Disorder
- Obsessive Compulsive Disorder
- Panic Attacks
- Personality Disorder
- Post-Traumatic Stress Disorder
- Schizophrenia
- Sleep Disorder
- Sexual Disorder
- Substance Abuse
- Thinking/Memory Disorder
- Other, please specify _____

18. Are you **CURRENTLY** receiving treatment or care for any mental or emotional conditions **excluding** addiction?
Yes _____ No _____ If yes, who is your care provider and what facility is he/she affiliated with?

Have you **PREVIOUSLY** received treatment for any mental or emotional conditions excluding addiction?
Yes _____ No _____ If yes, please provide the information below.

Facility or Care Provider	Inpatient or Outpatient	Admission & Discharge Dates	Diagnosis	Discharged with approval of provider? Yes/No



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19. Are you **CURRENTLY** receiving treatment or care for any type of addiction?

Yes _____ No _____ If yes, who is your care provider and what facility is he/she affiliated with?

Have you **PREVIOUSLY** received treatment for any type of addiction?

Yes _____ No _____ If yes, please provide the information below.

Facility or Care Provider	Inpatient or Outpatient	Admission & Discharge Dates	Diagnosis/Addiction	Discharged with approval of provider? Yes/No

Have you maintained sobriety or abstinence from addictive behavior? Yes _____ No _____

If yes, for how long? _____

What do you do to maintain your sobriety/abstinence?

If no, what prevents you from maintaining sobriety/abstinence?

20. Are you on any medications?

Yes, please list:

Medication	Dose

No

21. Are you involved in any current legal issues?

Yes, please specify:

No



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What symptoms/problems are you **CURRENTLY** experiencing or **HAVE** in the past experienced?

Check all that apply.

- Chronic Physical Illness
 - Cancer
 - Traumatic Head Injury
 - Diabetes
 - Heart Disease
 - Seizure Disorder
 - Thyroid Disease
 - Other: _____
- Frequent Pain
 - Abdominal Pain
 - Arthritis
 - Fibromyalgia
 - Migraines
 - Other: _____
- Physical Symptoms
 - Chest Pains
 - Headaches
 - Nausea
 - Weight Gain/Loss of More Than 10 Pounds in the Last 6 Months
 - Other: _____
- Sleep Disturbances
 - Difficulty Falling Asleep
 - Frequent Awakening
 - Sleep Too Little: Number of hours _____
 - Sleep Too Much: Number of hours _____
 - Obstructive Sleep Apnea
 - Other: _____
- Abuse
 - Emotional
 - Physical
 - Sexual
 - Spiritual
- Anger
- Convictions
 - Misdemeanor
 - Felony
 - Other: _____
- Financial Problems or Stresses
- Grief
- Lack/Loss of . . .
 - Ambition/Motivation
 - Concentration or Memory
 - Joy/Pleasure
 - Family Member/Friend
 - Spiritual Connection/Relationship with God
- Life Transition
 - Adoption
 - Career/Job Change
 - Unemployment
 - Elderly Parents
 - Empty Nest
 - Graduation
 - New Child
 - Retirement
 - Single Parent
 - Other: _____
- Loneliness/Sadness
- Military Service
 - Combat
 - Combat Injury
- Pregnancy Issues
 - Infertility
 - Loss of Pregnancy
 - Teenage Pregnancy
 - Termination (Post-Termination Issues)
 - Unplanned Pregnancy
 - Other: _____
- Relationship Issues
 - Blended Family
 - Children
 - Divorce
 - Friends
 - Infidelity
 - Parents
 - Rejection
 - Spouse/Partner
 - Separation
 - Supervisor/Teacher
 - Teenagers
 - Work Environment
 - Other: _____
- Self-Esteem
- Sexual Difficulties/Issues
 - Erectile Dysfunction
 - Gender Identity
 - Loss of Interest
 - Pornography
 - Promiscuity
 - Unfaithfulness
 - Other: _____
- Addictive Behavior
 - Alcohol
 - Cigarettes
 - Gambling
 - Illegal Drugs
 - Marijuana
 - Pornography
 - Prescription Drugs
 - Sexual
 - Other: _____
- Anxiety and/or Panic
 - Intrusive Thoughts
 - Panic Attacks
 - Social Anxiety
 - Fears
 - Phobias
- Disturbing Habits
 - Checking
 - Hand Washing
 - Hoarding
 - Other: _____
- Disturbing Thoughts (hearing or seeing things that others do not see or hear)
- Eating Issues
 - Anorexia
 - Bulimia
 - Compulsive Eating
 - Overeating
 - Binging
 - Loss of Appetite
- Flashbacks to Trauma
- Mood Changes
- Perfectionism
- Suicidal Thoughts
- Homicidal Thoughts



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34. Is there anything else that you want your counselor to know?

35. Have you ever submitted an intake form to the Compassion Counseling Center before? (circle one) Yes No

If yes, and your name has changed, please provide your former name: _____

36. How did you hear about the Compassion Counseling Center?

- | | |
|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Brochure | <input type="checkbox"/> Newsletter |
| <input type="checkbox"/> Church | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Friend | |
| <input type="checkbox"/> Internet | |

37. Appointment Preferences:

Appointments are on Monday evenings.

Time Preference:

- 7:00 pm
- 8:00 pm

Counselor Preference:

- Male Counselor Requested
- Female Counselor Requested
- No Preference

Every effort will be made to honor your preferences.

Compassion Counseling Center (CCC) has provided Christian lay counseling care since 2010. I understand that care is guided by Christian principles to heal and help people, with the unconditional love of Jesus and I consent to counseling and care at CCC.

Signature

mm/dd/yyyy

Thank you for completing the Intake Form.

Please return to: Compassion Counseling Center
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