The Center for Family Counseling and Education

Adult Client Information

(This information is to be provided to CFCE by the client prior to their initial intake assessment session)

Personal information

Name (first, middle initial, last):		
Street Address:		
City:		
State:		Postal code:
Phone numbers (include area codes)		
Home:		Cell:
Work:		OK to contact at work? Yes ☐ No ☐
Email address:		
Home:		
Work:		
OK to contact at work? Yes ☐ No ☐		
Male ☐ Female ☐	Age:	Date of birth (mm/dd/yyyy): / /
Please check the box following the term(s) which best describe your ethnicity: African ☐ Asian ☐ Eastern European ☐ Far Eastern ☐ Hispanic ☐ Middle Eastern ☐ Native American ☐ Near Eastern ☐ Pacific Islander ☐ Western European ☐ Other (describe) ☐		
Occupation:		
How long have you been employed at your current place of employment? years months		
Education (please circle the year of the highest level you have completed)		
High school: 9 10 11 12 College: 1 2 3 4 Graduate school: 1 2 3 4 Doctorate: 1 2 3 4		
Diploma(s) and/or degrees earned:		
In case of emergency contact:		
Name (first, middle initial, last):		
Relationship to you:		
Phone number (please include area code):		
Street address:		
City:		
State:		Postal code:
Email address:		Total monthly household income: $_____

Marital information

Current marital status

Please check the box(es) following the description(s) that best describe(s) your current marital status: married and cohabiting ☐ married but living separately ☐ legally separated ☐ divorced ☐ not married but cohabiting ☐ never married, never cohabited ☐	
If married, for how long? years months	Cohabitation prior to marriage? Yes ☐ No ☐
If cohabiting, for how long? years months	Reason(s) for decision to cohabit?

If married, rate your relationship with your spouse: excellent ☐ good ☐ fair ☐ poor ☐ unbearable ☐
If cohabiting, rate your relationship with your partner: excellent ☐ good ☐ fair ☐ poor ☐ unbearable ☐
If married, will your spouse be participating in your counseling? Yes ☐ No ☐
If cohabiting, will your partner be participating in your counseling? Yes ☐ No ☐

Marital spouse/cohabitational partner

Name (first, middle initial, last):	
Street address (if different from client's)	
City:	
State:	Postal code:
Phone numbers (please include area codes)	
Home:	Cell:
Work:	OK to contact at work? Yes ☐ No ☐
Age:	Date of birth (mm/dd/yyyy): / /

History

Previous marriage(s)? Yes ☐ No ☐ (If yes, please indicate the number of times):
Divorced? Yes ☐ No ☐ (If yes, please indicate the number of times)
Death of spouse? Yes ☐ No ☐ (If yes, please indicate the number of times)

Family information

Current cohabitants

Members of present household (please indicate the number of each currently living with you)			
Children:	Stepchildren:	Foster children:	Grandchildren:
Parents:	Other relatives:	Friends:	
Which terms best describe your current home environment? harmonious ☐ battleground ☐ peaceful ☐ clamorous ☐ orderly ☐ chaotic ☐ happy ☐ unhappy ☐ supportive ☐ destructive ☐ welcoming ☐ hostile ☐			

Family of origin

Please indicate who raised you by checking the box following the best choice: biological parents ☐ biological parent/step parent ☐ foster parents ☐ adoptive parents ☐					
Please indicate where you are in the birth order of your biological siblings (1st, 2nd, 3rd, etc. out of how many siblings)					
Which terms best describe the home environment in which you were raised? harmonious ☐ battleground ☐ peaceful ☐ clamorous ☐ orderly ☐ chaotic ☐ happy ☐ unhappy ☐ supportive ☐ destructive ☐ welcoming ☐ hostile ☐					
Please check all below who are still living, indicate to the right of the check box how many of each are still living, and place a check in the column beneath the term which best describes your present relationship with that person or those people (please leave blank if you have no relationship with that person or those people):					
	Excellent	Good	Fair	Poor	Unbearable
mother ☐	☐	☐	☐	☐	☐
stepmother ☐	☐	☐	☐	☐	☐
father ☐	☐	☐	☐	☐	☐

stepfather ☐	☐	☐	☐	☐	☐
brother(s) ☐	☐	☐	☐	☐	☐
stepbrother(s) ☐	☐	☐	☐	☐	☐
sister(s) ☐	☐	☐	☐	☐	☐
stepsister(s) ☐	☐	☐	☐	☐	☐
Children ☐	☐	☐	☐	☐	☐

Medical information

Primary care physician

Name:	
Street Address:	
City:	
State:	Postal code:
Phone number (please include area code):	
Email address:	

Current medical condition

Please check the box next to the phrase which best describes your current physical condition: Excellent health, no health problems or concerns ☐ Good health, few health problems or concerns ☐ Fair health, several health problems or concerns ☐ Poor health, many health problems or concerns ☐
Please list any medical conditions for which you are currently being treated by a medical professional:
Please list any physical problems (injuries, illnesses, pains, disabilities, etc.) that you currently have but for which you are not currently being treated by a medical professional:
Please list any serious medical conditions for which you have been treated by a medical professional in the past (include surgeries, hospital stays, etc.)
Please list any medications that you are currently taking:

Psychological information

Have you previously received psychiatric treatment, psychological therapy, or mental health counseling? Yes ☐ No ☐ Is there any history of mental illness in your family? Yes ☐ No ☐
If yes, please provide as much detailed information on the back of this sheet about this experience as possible including dates, durations, types of treatment, name and type of therapist (psychiatrist, psychologist, mental health counselor, social worker, spiritual counselor, etc.), results, and your impressions of the experience.

Please check any of the following which you feel apply to you or that you have been told apply to you:			
Depressed ☐	Anxious ☐	Fearful ☐	Isolated ☐
Obsessive ☐	Unpredictable ☐	Domineering ☐	Submissive ☐
Absent-minded ☐	Forgetful ☐	Arrogant ☐	Abusive ☐
Problem keeping this/these feeling(s) under control: Anger ☐ Irritation ☐ Worries ☐ Fear ☐ Suspicion ☐ Inadequacy ☐ Worthlessness ☐ Helplessness ☐ Hopelessness ☐ Superiority ☐ On top of the world ☐ Pessimism ☐		Experienced(ing) problem(s) with: Addiction(s) ☐ Distinguishing what is real and what is not ☐ Uncontrollable thoughts ☐ Internal voices ☐ Visual hallucinations ☐ Audible hallucinations ☐ Feeling like you are somewhere else ☐ Feeling like you are someone else ☐	

Spiritual information

Please check any of the following which you believe apply to you:			
Religious ☐	Spiritual ☐	Agnostic ☐	Atheist ☐
Interested in learning more about spiritual matters ☐		Not interested in spiritual matters ☐	
I believe that the Bible is (check the response or responses which most closely approximates your position): Mostly myths and out-of-date-teachings ☐ A good book ☐ God's Holy Spirit-breathed Word ☐ From Genesis 1:1 to Revelation 22:21 the completed self-revelation of God to man in written form ☐ Absolute, universal, reliable, and eternal truth from God and the final authority for all things regarding my Christian faith and practice ☐			
I believe that God is (check the response or responses which most closely approximates your position): Nonexistent ☐ A concept created by man ☐ Real but unreachable and/or unknowable ☐ A higher form of being who evolved by progressive accomplishments and/or improvements ☐ A combination of what all human religions teach about divine being(s) ☐ Exactly who he said he is and revealed himself to be in the Bible ☐			
Christian ☐ Church member? Yes ☐ No ☐ If yes, where? If yes, how long? If yes, how often do you attend regularly scheduled services? _____times per week ☐ month ☐ year ☐ If yes, currently active in church ministry? Very ☐ Somewhat ☐ No ☐ If no, interested in joining a church? Yes ☐ No ☐		Other religion/faith ☐ Please describe:	
If Christian, please check any of the following which you believe apply to you:			
Holy Spirit-regenerated (spiritually born-again) ☐ Date of rebirth: / /			New convert ☐
Committed learner ☐	Discipled ☐	Spiritually mature ☐	Believer's baptism ☐
Sin issues with which you are currently struggling: Lust ☐ Immorality ☐ Envy ☐ Greed ☐ Jealousy ☐ Fear ☐ Unrighteous Anger ☐ Lack of forgiveness ☐ Lack of consistency ☐			
How often do you meditate on scripture? _____ times each day ☐ week ☐ month ☐			
How often do you communicate with God in prayer? _____ times each day ☐ week ☐ month ☐			
Are you involved in a mentoring/accountability relationship with a more mature Christian? Yes ☐ No ☐ If no, would you be interested in becoming involved in such a relationship? Yes ☐ No ☐			