BIBLICAL COUNSELING CENTER OF ROCHESTER

Counseling Intake

Name:_____ Date: _____

Date of Birth: _____ Military Service?: _____

Home Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address:_____ Arrest history: _____

May we call you and leave messages at home? Yes No *May we add you to out data base? Yes No*

Marital Status: □ S □ M □ D □ W Date of Current Marriage/Separation:_____ # of Marriages____

Previously Married? □ Yes □ No If yes, when?_____ How long? _____

Occupation: _____ Highest level of education:_____

Spouse's Name _____ Date of Birth: _____

Previously Married? □ Yes □ No If yes, when?_____ How long? _____

Spouse occupation:_____ Highest level of education:_____

Child(ren)'s Name(s) _____ Date of Birth: _____□ M □ F

_____ Date of Birth: _____□ M □ F

_____ Date of Birth: _____□ M □ F

Medical History

How would you rate your current physical health? □ Excellent □ Good □ Fair □ Poor

Are you currently experiencing any physical problems (e.g.: headaches, body aches, stomach problems)?
□ Yes □ No
If yes, please explain:_____

_____

Previous hospitalizations for medical reasons: Date:_____ Reason:_____

Date:_____ Reason_____

Please list any medical conditions or disabilities:_____

_____

Please list any learning disabilities:_____

Medications Over the counter or prescription	Dosage

Counseling and Psychiatric History

Have you had previous individual counseling? □ Yes □No If yes, when?_____

If yes, for what reason?_____For how long?_____

Have you ever been diagnosed with or treated for any type of mental illness? □ Yes □ No If yes, which type?_____

Has anyone in your family ever been diagnosed with or treated for any type of mental illness? □Yes □ No

If yes, which type?_____

Psychiatric Medications	Dosage

Reasons for Seeking Help

What concerns have brought you to counseling today?_____

_____

What have you done about it? _____

When did your present concerns begin to be a problem for you?_____

What concerns have been identified by others?_____

Please rate the severity of your present concerns on the following scale. Check one.

□ Mild □ Moderate □ Severe □ Totally Incapacitating

Please indicate which of the following areas are currently problems for you. Check all that apply.

□ Feeling inferior to others

□ Under too much pressure or feeling stressed

□ Feeling down or unhappy/depressed mood

□ Excessive Worry or Anxiety

□ Feeling Lonely

□ Suspicious feelings toward other people

□ Afraid of being on your own

□ Angry Feelings

□ Concerns about finances

□ Feeling "numb" or cut off from emotions

□ Concerns about physical health

□Not being able to say what you really think or feel

□ Angry Outbursts

□ Excessive fear of specific places or objects

□ Difficulty making friends

□ Difficulty keeping friends

□ Feeling as if you'd be better off dead

□ Feeling manipulated or controlled by others

□ Difficulty making decisions

□ Loss of interest in sexual relationships

□ Feeling sexually attracted to members of your own sex

□ Feeling distant from God

□ Concerns about mental stability

□ Tremors

□ Blackouts or temporary loss of memory

□ Insomnia (not being able to sleep)

□ Loss of appetite/increased appetite

□ Uncontrollable anxiety or worry

□ Lacking self-confidence

□ Feeling Fat

□ Eating then vomiting to control weight

□ Excessive use of alcohol

□ Abuse of non-prescription drugs

□ Getting into trouble at school/work

□ Other:_____

□ Hallucinations

□ Hypersomnia (Sleeping all the time)

□ Inability to concentrate while at school/work

□ Crying Spells

□ Feeling of "on top of the world"

□ Nightmares

□ Loss of interest in usual activities/lack of motivation

□ Obsessions or compulsions with specific activities

□ Inability to control thoughts

□ Feeling trapped in rooms/buildings

□ Hearing voices

□ Feeling that people are "out to get you" or that you are being watched

□ Delusions

What do you hope to gain from counseling?_____

_____

How did you hear about BCCR? :_____

Spirituality

Do you believe in God? □ Yes □ No What is your religious preference?_____

Are you a member of a church? □ Yes □ No If yes, what church?_____

How much influence does your religion have on your day-to-day activity?_____

Have you personally received Christ into your life as Savior (born again, saved)? _____

How often do you read your Bible? _____

How often do you have personal or family devotions? _____

Is there any other information that might be helpful for us to know? _____

How many hours of sleep do you average per night? _____

Have you had any thoughts about taking your own life or the life of another? Yes No

Please explain.

In signing this I agree not to call my counselor into court and I give up my right to subpoena any records or notes.
The counselors of the BCCR are here to spiritually help you and will not aid you in any legal actions at all.
I have read the conditions for counseling and understand them. I have honestly answered all of the questions.

Signed _____

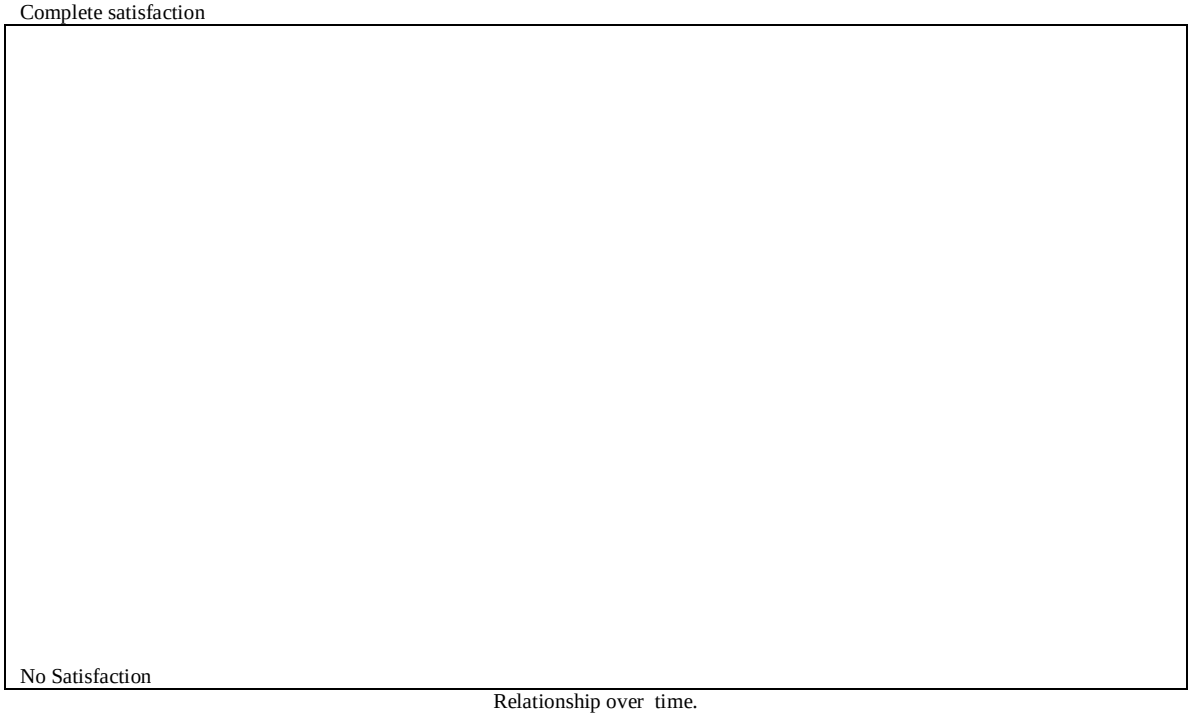
Date _____

If you are here for marriage counseling please complete the following questions.

Additional Marital Counseling Information

Please draw a graph indicating your level of marital satisfaction beginning with when you met your spouse. Note pivotal events in your relationship.

Complete satisfaction



No Satisfaction

Relationship over time.

Please rate your current level of marital happiness by circling the number which corresponds with your current feelings about the relationship.

0	1	2	3	4	5	6
Extremely Unhappy	Fairly Unhappy	A Little Unhappy	Happy	Very Happy	Extremely Happy	Perfect

1. Have you ever been to counseling as a result of problems with this relationship prior to today? _____
   If so, what was the outcome of that counseling? _____
   _____
   _____

2. Has your spouse been in individual counseling before? _____ If so, give a brief summary.
   _____
   _____

3. Do either you or your spouse drink alcohol or take non-prescription drugs? _____ If yes for either, who, how often and what drugs or alcohol?
   _____

4. Have either you or your spouse struck, physically restrained, used violence against or injured the other person within the last three years? _____ If yes for either, who, how often and what happened?

_____

_____

5. Have either of you threatened to separate or divorce as a result of the current marital problems? _____

6. Have either you or your spouse consulted with a lawyer about divorce? _____ If yes, who? _____

7. Do you perceive that either you or your spouse have withdrawn from the marriage? _____ If yes, which of you has withdrawn? _____

8. How frequently have you had sexual relations in the last month? _____ times

9. How enjoyable is your sexual relationship? (Circle One)

Terrible More unpleasant than pleasant Not Pleasant, not unpleasant More pleasant than unpleasant Great

10. How satisfied are you with the frequency of your sexual relations? (Circle One)

Way too often To suit me	A bit too often to suit me	About Right	A bit too seldom to suit me	Way too seldom to suit me

11. What is your current level of stress? (Circle One)

Very High High Moderate Low Very Low Extremely Low

12. To what degree do you have family or friends that support you as a couple? (Circle One)

Extremely high Very High High Moderate Low Very Low Extremely Low

13. To what degree do the two of you share a similar basic worldview? (Circle One)

Extremely High Very High High Moderate Low Very Low Extremely Low

14. Was your childhood stable or unstable? _____ Please explain.

15. Was your spouse's childhood stable or unstable? _____ Please explain.