5750 Rufe Snow Drive, Ste 130
North Richland Hills, Texas 76180
817.707.5735
www.lighthousecc.biz

Confidential Client Counseling Intake

Name: _____ Date: _____ DOB: _____

Home Address: _____ Sex: Male ❑ Female ❑

City, State, Zip: _____ SS #: _____-_____-_____

Home Phone: (_____) _____ - _____ DL# _____

Cell Phone: (_____) _____ - _____ Email: _____

Employer: _____ _____ Work Phone: (_____) _____ -_____

May we call you at: Home: Yes ❑ No ❑ Work: Yes ❑ No ❑ Cell: Yes ❑ No ❑

May we send mail to you at your home address? Yes ❑ No ❑

Marital Status: Never Married ❑ Married ❑ Widowed ❑ Separated ❑ Divorced ❑

Marriage Date: _____/ _____/ _____

Spouse's Name: _____ DOB _____/ _____/ _____

Children's Names: _____ DOB _____/ _____/ _____

_____ DOB _____/ _____/ _____

_____ DOB _____/ _____/ _____

Previous Marriage: Yes ❑ No ❑ Name of Previous Spouse: _____

How Long? _____

Highest Level of Education: _____

Spouse's _____

Health Insurance Information

Insured Name: _____ SS#: _____ -_____ - _____
DOB: _____/ _____/ _____

Insurance Company: _____ Group#: _____

ID#: _____

Address: _____

City, State, Zip: _____

Benefits / Eligibility Phone #: (_____) _____ - _____

Insured Employer: _____

Employer's Address: _____

City, State, Zip: _____

Health & Personal Information

Would you describe your current physical health as: Excellent ❑ Good ❑ Fair ❑ Poor ❑

Would you describe your current diet as: Excellent ❑ Good ❑ Fair ❑ Poor ❑

How many hours do you sleep each night? _____

Do you currently have any physical problems? Yes ❑ No ❑ If yes, please explain:

_____

_____

Please list any medical conditions or any disabilities:

_____

_____

Have you or anyone in your family ever been diagnosed or treated for any mental illness?
Yes ❑ No ❑ If yes, explain:

_____

_____

Have you ever been in counseling before? Yes ❑ No ❑ If yes, please provide counselor name and location, dates and reason for counseling:

_____

_____

Have you ever been admitted as inpatient or outpatient in a hospital for mental health issues?
Yes ❑ No ❑ If yes, please give issue, dates and hospital:

_____

Please list all prescription and OTC medications currently being taken:

Medication	Dosage	Physician	Purpose

Have you ever taken illegal drugs? Yes ❑ No ❑

Do you drink alcoholic beverages Yes ❑ No ❑ How many average per day? _____ per week?_____

Are religious or spiritual issues important to you? Yes ❑ No ❑

How much do they impact/influence your daily life?
A great deal ❑ A reasonable amount ❑ Some ❑ Very little ❑

Do you currently attend church? Yes ❑ No ❑

If yes, where do you attend?
_____

How did you hear about Lighthouse Christian Counseling?
_____

What concerns are you seeking counseling for today?

_____

_____

_____

How often are you troubled by these concerns?

Constantly ❑ Often ❑ Sometimes ❑ Not very often ❑

Please indicate your current level of the following symptoms or behaviors:

	Never	Rarely	Sometimes	Frequently
Feeling angry or having outbursts:	❑	❑	❑	❑
Inability to control my thoughts:	❑	❑	❑	❑
No one cares about me:	❑	❑	❑	❑
Loss of, or increased appetite:	❑	❑	❑	❑
Feeling distant from God:	❑	❑	❑	❑
Trouble controlling worry or anxiety:	❑	❑	❑	❑
Life is hopeless:	❑	❑	❑	❑
Concerns with emotional stability:	❑	❑	❑	❑
Withdrawing from relationships:	❑	❑	❑	❑
Excessive use of alcohol or drugs:	❑	❑	❑	❑
Trouble concentrating:	❑	❑	❑	❑
Loss of sexual interest:	❑	❑	❑	❑
I am lonely:	❑	❑	❑	❑
Feelings of depression:	❑	❑	❑	❑
Easily distracted:	❑	❑	❑	❑
People are out to get me:	❑	❑	❑	❑
Wanting to sleep all the time:	❑	❑	❑	❑
Nightmares:	❑	❑	❑	❑
Often fatigued:	❑	❑	❑	❑
Avoiding people:	❑	❑	❑	❑
Afraid of specific places or things:	❑	❑	❑	❑
Excessive recurring thoughts:	❑	❑	❑	❑

	Never	Rarely	Sometimes	Frequently
Lack of interest/motivation in activities:	❑	❑	❑	❑
Getting into trouble at school/work:	❑	❑	❑	❑
Having little self confidence:	❑	❑	❑	❑
I do not deserve to be forgiven:	❑	❑	❑	❑
Feeling numb, having no emotions:	❑	❑	❑	❑
Out of control:	❑	❑	❑	❑
Afraid of being alone:	❑	❑	❑	❑
Insomnia:	❑	❑	❑	❑
I hear voices:	❑	❑	❑	❑
Feeling of being disoriented:	❑	❑	❑	❑
Why do I feel so different?	❑	❑	❑	❑
Most people don't like me:	❑	❑	❑	❑
Obsession with certain activities:	❑	❑	❑	❑
Feeling of stress, under too much pressure:	❑	❑	❑	❑
I want to hurt someone:	❑	❑	❑	❑
I cant do anything right:	❑	❑	❑	❑
Mood shifts:	❑	❑	❑	❑
Trouble making or keeping friends:	❑	❑	❑	❑
Feeling fat:	❑	❑	❑	❑
People manipulate or control me:	❑	❑	❑	❑
I am often physically sick:	❑	❑	❑	❑

Emergency Contact

Who should we contact in case of an emergency?

Name: _____ Relationship:_____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Address:_____

City, State, Zip: _____

Client Signature:

_____