SHAEFFER
COUNSELING SERVICES

**Name**: _____ Gender: _____ Age: _____

Address: _____ City: _____ Zip: _____

Primary Phone Number: _____ May we leave a message here: ❑ Yes ❑ No

Second Phone Number: _____ May we leave a message here: ❑ Yes ❑ No

Birth date: _____ / _____ /_____ Email Address: _____

Occupation / Employer: _____ Avg Hours/Week: _____

If you are a student what school do you attend? _____

Highest degree(s) earned: _____

## Marriage & Family Information

With whom do you currently live? (*Please check all that apply*)

❑Alone ❑ Parent(s) ❑ Spouse ❑ Children ❑ Boyfriend ❑ Girlfriend ❑ Roommate(s): #_____

If you are in a relationship please fill out the following information:

Name of Significant Other_____ Age _____

Address: (❑ same as above) _____

Phone #: _____ Email Address: _____

Occupation /Employer or School: _____

Are they willing to come to counseling? ❑ Yes ❑ No ❑ Uncertain

If you are married please provide the information below:

Date of Marriage: _____ Your age when you married: _____ Spouse's Age _____

Have you ever been separated? ❑ Yes ❑ No ❑ Currently When/How long? _____

Length of steady dating: _____ Length of engagement: _____

Children:

| Child's Name | Age | Gender | Living | At Home | Married | Special Condition(s) (i.e. adopted, previous marriage) |
|---|---|---|---|---|---|---|
| | | | *Y/ N* | *Y/N* | *Y/N* | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

If you have been divorced please fill in the boxes below: *(please use the back of page if you need more space)*

| Ex-Spouse's Name | Years Married | Length of Marriage | Reason for Divorce | # Kids |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Number of brothers: _____ sisters: _____ The town I grew up in was: ❑ urban ❑ suburban ❑ rural

My family's financial situation was ❑ poor ❑ middle class ❑ wealthy

Number of times you have moved before the age of 18 _____

Did you ever have any significant traumatic events as a child? If yes please briefly describe:

_____
_____
_____
_____

Please describe any family history (the family you grew up in), which might be pertinent to the concerns that you bring to counseling (your relationship with you parents, their relationship with each other, significant losses or events etc):

_____
_____
_____

## Faith

How much does religious faith play in your life? ❑ None at all ❑ A little bit ❑ Mildly ❑ Very much so

Do you attend worship somewhere on a regular basis? ❑ Yes ❑ No

If yes, please share where: _____ How often? _____

## Health Information

Have you had counseling before? ❑ Yes ❑ No Have you seen a psychiatrist before? ❑ Yes ❑ No

| Age | Duration | Counselor / Center | Issue(s) / Topic(s) /Diagnosis | Your evaluation of Counseling |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Approximately how many hours of sleep do you get each night? _____ When do you normally go to bed? _____

Describe any recent changes in sleep habits: _____

State of health: ❑ Very good ❑ Good ❑ Average ❑ Declining ❑ Other: _____

Date of last medical examination: _____ Results: _____

Current illness, injury, or disability: _____

Are you presently taking any medication? ❑ Yes ❑ No Prescribing Doctor(s): _____

| **Medication** | **Dosage** | **Frequency** | **Prescribed for…** | **Date began taking…** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Have you used drugs for other than medical purposes? ❑ Yes ❑ No

If currently: What do you take? _____ How often _____ How much? _____

If in the past how long ago? _____ What did you take? _____

Do you drink alcoholic beverages? ❑ Yes ❑ No How often _____ How much? _____

Have you had any changes in your diet in the past 6 months? ❑ Yes ❑ No

If you have an exercise routine please describe: _____

Current weight? _____ lbs Weight changes: **6 months** +/- _____ lbs **1 Year** +/- _____ **5 Years** +/-_____

Number of non-working hours you spend watching television _____ on computer _____ hobbies _____

Please check any of the following physiological symptoms that apply to you.

| | | |
|---|---|---|
| Headaches ……. ❑ Past ❑ Present | Difficult Breathing. ❑ Past ❑ Present | Rapid Heart Rate.. ❑ Past ❑ Present |
| Visual Troubles…. ❑ Past ❑ Present | Tension…… ❑ Past ❑ Present | Dizziness…… ❑ Past ❑ Present |
| Weakness. ……. ❑ Past ❑ Present | Fatigue…… ❑ Past ❑ Present | Pain…… ❑ Past ❑ Present |
| Sleep Trouble……. ❑ Past ❑ Present | Change in Appetite ❑ Past ❑ Present | Other (on back).... ❑ Past ❑ Present |

**Check any of the following struggles you and /or your family are experiencing at this present time:**
**Please rate: "leave blank for none; "1" if mild; "2" if moderate; or "3" for severe.**

| *You* | *Family* | | *You* | *Family* | | *You* | *Family* | |
|---|---|---|---|---|---|---|---|---|
| | | *Abuse, Physical* | | | *Gender dysphoria* | | | *Pornography* |
| | | *Abuse, Sexual* | | | *Greed* | | | *Pride* |
| | | *Abuse, Verbal* | | | *Grief* | | | *Priorities* |
| | | *Abuse in the past* | | | *Guilt* | | | *Procrastination* |
| | | *Addiction* | | | *Identity* | | | *Purpose, Lack there of* |
| | | *Anger* | | | *Impatience* | | | *Rebellion* |
| | | *Anxiety* | | | *Infertility* | | | *Rejection* |
| | | *Apathy* | | | *Insecurity* | | | *Relationships* |
| | | *Bitterness* | | | *In-Law conflict* | | | *Respecting authorities* |
| | | *Caring for parents* | | | *Jealousy* | | | *Same sex attraction* |
| | | *Codependency* | | | *Lifestyle change* | | | *Self-control* |
| | | *Compulsions* | | | *Loneliness* | | | *Self-injury* |
| | | *Depression* | | | *Lying* | | | *Selfishness* |
| | | *Debt* | | | *Manipulation* | | | *Sex issues* |
| | | *Discontentment* | | | *Marital intimacy* | | | *Shame* |
| | | *Divorce recovery* | | | *Moodiness* | | | *Social anxiety* |
| | | *Eating disorder* | | | *Panic attacks* | | | *Spiritual growth* |
| | | *Empty nest* | | | *Parenting* | | | *Submission* |
| | | *Envy* | | | *Parenting adult child* | | | *Suicidal thinking* |
| | | *Fear* | | | *People pleasing* | | | *Time management* |
| | | *Financial management* | | | *Perfectionism* | | | *Work unfulfilling* |
| | | | | | | | | |
| | | | | | | | | |

- ***If issues not covered please write in empty spaces***

**Please complete the following:**

In order to understand me _____
_____
My ambition in life is to _____
What really hurts me _____

I get nervous when _____
I wish I could lose my fear of _____
What I wish I could change about myself _____
My best childhood memory _____
My worst childhood memory _____
My father was/is _____
My mother was/is_____
My greatest achievement is _____
My role in my current family is _____
For refuge / rest I turn to _____
When life gets too tough I _____
To be happy I need _____
I would do anything for _____
I often wonder why _____
It would embarrasses me to _____
I cannot decide _____

Indicate how distressed you are by placing an "x" on the scale below ( 1 = very little distress; 10 extreme distress):

**1 2 3 4 5 6 7 8 9 10**

1) Please describe the issue (s) that bring you to counseling _____
_____
_____
_____
_____
_____
2) What have you done about it so far? _____
_____
3) Other than counseling, what help are you seeking? _____
_____
4) What are your expectations coming here?_____
_____
5) What are your concerns coming to counseling? _____
_____
6) What do you believe has to change to produce the progress you desire? _____
_____
7) Is there any other information we should know? _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Thank you for your time in filling this intake form. It helps our counselors have a better sense of who you are.