

BIBLICAL COUNSELING INTAKE FORM

NAME: _____

CELL PHONE: _____

HOME PHONE: _____

E-MAIL: _____

MAILING ADDRESS: _____

GENDER: _____ BIRTH DATE: _____ AGE: _____

MARITAL STATUS: ___ Single ___ Engaged ___ Married ___ Separated ___ Divorced ___ Widowed

EDUCATION: Last Grade Completed _____

OCCUPATION: _____

NAME OF SPOUSE: _____ YEARS MARRIED: _____

CHILDREN'S NAMES AND AGES:

BRIEFLY ANSWER THE FOLLOWING QUESTIONS:

1. Please describe the current problem for which you are seeking Biblical counseling.

2. What have you attempted to do to alleviate the problem (if anything)?

3. What do you hope to achieve through the Biblical counseling process? Briefly list two to three goals.

4. Have you sought other outside help? If so, from whom?

5. Are you a believer in Jesus Christ? Yes No (circle one)

6. Please explain the Gospel as you understand it in the space provided below:

ASSESSMENT

Please check all the following that apply to you at this time:

- | | |
|---|---|
| <input type="checkbox"/> I feel depressed | <input type="checkbox"/> I feel anxious |
| <input type="checkbox"/> I am having marital problems | <input type="checkbox"/> I struggle with my in-laws |
| <input type="checkbox"/> I have children | <input type="checkbox"/> I struggle as a parent |
| <input type="checkbox"/> I abuse alcohol | <input type="checkbox"/> I use illegal drugs |
| <input type="checkbox"/> I use prescription drugs | <input type="checkbox"/> I abuse prescription drugs |
| <input type="checkbox"/> I view pornography | <input type="checkbox"/> I struggle sexually |
| <input type="checkbox"/> I feel hopeless | <input type="checkbox"/> I feel fearful |
| <input type="checkbox"/> I feel angry | <input type="checkbox"/> I struggle with anger |
| <input type="checkbox"/> I am a poor communicator | <input type="checkbox"/> I feel sad |
| <input type="checkbox"/> I struggle with bitterness | <input type="checkbox"/> I feel worthless |
| <input type="checkbox"/> I do not attend church regularly | <input type="checkbox"/> I do not read my Bible often |
| <input type="checkbox"/> Jesus is important in my life | <input type="checkbox"/> I don't think about Jesus much |
| <input type="checkbox"/> I strongly fear rejection | <input type="checkbox"/> I have been sexually abused |
| <input type="checkbox"/> I have been physically abused | <input type="checkbox"/> I have been verbally abused |
| <input type="checkbox"/> I have been sexually abusive | <input type="checkbox"/> I have been physically abusive |

CHURCH AFFILIATION

- 1. Are you a member of a local church? Yes No (circle one)
- 2. If so, what is the name of the church you attend _____
how long have you attended this church? _____
- 3. Are you actively involved in your church? Yes No (circle one)
- 4. Do you have a person/people to whom you are accountable at your church? Yes No (circle one)
- 5. Do you believe being an active part of a community of believers is important to reaching your goals in biblical counseling? Why? Why not?

6. How did you hear about Spotswood Biblical Counseling Center? _____

EMERGENCIES

We can be reached at 540-940-2940 Monday-Thursday, from 10am-3pm. We are not a 24 hour crisis/emergency center. If you are unable to reach us in a timely manner, you should contact your physician, a local emergency room or the local police department when necessary and appropriate. It is your responsibility to seek the appropriate resources in emergency situations. By your signature below, you indicate that you have read and understood this statement, and any questions about this statement were answered to your satisfaction. You also indicate that you have received a copy of this statement for your records. By our signature it verifies the accuracy of this statement and acknowledges my commitment to conform to its specifications.

Client Name (Print): _____

Signature of Client: _____

Date: _____

Biblical Counselor Name (Printed): _____

Signature of Biblical Counselor: _____

Date: _____