WrightWay Minstries

"Pathway to the Abundant Life"
Professional Christian Counseling Services

Frankie M Wright, MA, LCPC

Client Intake Form

Welcome to Wright Way Ministries! Thank you for taking a few minutes to fill out this form. The information you provide is confidential, and will be helpful for you and your counselor when you meet for the first time. If you have any questions, just ask! **(Please print clearly using black or blue ink.) Thank you!**

Today's Date_____

Name _____Age _____ Date of Birth___/ ___/ ____ SSN: ___ - ___ - ____
(Last) (First) (MI)

Name of parent/guardian (if under 18 years): _____
(Last) (First) (MI)

Address: _____
(Street) (City) (State) (Zip)

Phone (Primary) (___) _____ (Secondary) (___) _____ May we leave a message? ☐ Yes ☐ No

E-mail (please print clearly): _____ May we email you? ☐ Yes ☐ No
***Please note: Email correspondence is not considered to be a confidential medium of communication.**

Ethnicity: _____ Where did you grow up? _____

Highest Level of Education Completed: _____ Current Occupation_____

Employer:_____ Phone: (____)_____

Address: _____
(Street) (City) (State) (Zip)

What is your religious background / involvement? _____

Church Attending (currently) _____

EMERGENCY CONTACT PERSON(S):

Name:	Relationship:	Phone #:	Address:
_____	_____	_____	_____
_____	_____	_____	_____

CLOSEST RELATIONSHIPS: (please list name, birth date, relationship, and whether they live with you)

Name:	Birth Date:	Relationship:	Living with you?
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No

Please describe your current living arrangement: Live Alone? ☐ Yes ☐ No **(if no, please list below)**

Name:	Birth Date:	Relationship:
_____	_____	_____
_____	_____	_____

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FAMILY INFORMATION:

Marital Status (check any that apply): ☐ Single ☐ Dating ☐ Committed Relationship ☐ Engaged ☐ Widowed ☐ Married (how long? (_____) ☐ Separated (how long? _____) ☐ Divorced (how long? _____)

Spouse's Name (if applicable) _____ **Age:** _____ **Date of Birth**___/ ___/ _____

Highest Level of Education Completed: _____ **Current Occupation**_____

Employer:_____ **Phone: (301)** _____

Address: _____

(Street) (City) (State) (Zip)

I would describe my friendships as: ☐ Close ☐ Somewhat Close ☐ Distant ☐ Conflicted

I would describe my relationship with my mother as: ☐ Close ☐ Somewhat Close ☐ Distant ☐ Conflicted

I would describe my relationship with my father as: ☐ Close ☐ Somewhat Close ☐ Distant ☐ Conflicted

How many siblings do you have? ____ **How would you describe your relationship?** _____

_____

INSURANCE:

I will use insurance? ☐ Y ☐ N **(If yes, please provide the following information)**

Company _____ **Claims Telephone Number (**____**)** _____

Type of plan ☐ PPO ☐ HMO ☐POS **Policy Holder/Subscriber** _____

(Note: if client is a minor, please complete the following employment information for parent/guardians' employment)

Employer/Company _____ **Job Title** _____ **Gross Salary $**_____

Street Address _____ **City**_____ **State** _____ **Zip Code** _____

LEGAL HISTORY (arrests, prison, DWI, parking tickets?)_____

MEDICAL INFORMATION: Doctor's name and phone #: _____ **PH: (**____**)** _____

May we send your doctor a short note, letting him / her know you've come to see us? (We do not release details other than your name, for referral purposes) ☐ Y ☐ N **(if yes, provide address:** _____**)**

Please list any conditions, illnesses, treatments, or surgeries that might be relevant to your reason for seeking counseling:

_____

Are you currently taking any prescription medications? ☐ Y ☐ N

Please list all current medications you are taking and the reasons for taking them. (List even if you seldom use, or take only as needed.)		
Name of Medication	**Dose**	**Reason for taking**

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Have you participated in any therapy before? ☐ Y ☐ N If yes, when? _____ Reason_____

Are you, currently seeing a psychiatrist, therapist, or helper? ☐ Y ☐ N If yes, previous therapist/practitioner name:

_____

Have you ever been prescribed psychiatric medications? ☐ Y ☐ N

Please list all psychiatric medications you are taking and the reason for taking them.			
Name of Medication	**Dosage/Frequency**	**Reason for taking**	**Date**

Are you taking medications as prescribed? ☐ Y ☐ N If no, please explain: _____

Date and outcome of last physical exam: Date: ___/ ___/ _____ Outcome:_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (i.e., father, grandmother, uncle, etc.)

Issue		List Family Member
Alcohol/Substance Abuse	☐ Y ☐ N	
Anxiety	☐ Y ☐ N	
Depression	☐ Y ☐ N	
Domestic Violence	☐ Y ☐ N	
Eating Disorders	☐ Y ☐ N	
Obesity	☐ Y ☐ N	
Obsessive Compulsive Behavior	☐ Y ☐ N	
Schizophrenia	☐ Y ☐ N	
Suicide Attempts	☐ Y ☐ N	

Have you or a family member ever been hospitalized for a mental or emotional illness? ☐ Y ☐ N If yes, explain:

_____ _____ _____

(Date) (Place) (Reason)

SUBSTANCE ABUSE/ ADDICTION HISTORY? ☐ Y (please explain) ☐ N _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. **How would you rate your current physical health? (please circle)**

   Poor Unsatisfactory Satisfactory Good Very good

   Please list any specific health problems you are currently experiencing?_____

   _____

2. **How would you rate your current sleeping habits? (please circle)**
   Poor Unsatisfactory Satisfactory Good Very good

   Please list any specific sleep problems you are currently experiencing?_____

   _____

3. **How many times per week do you generally exercise?** _____
   What types of exercise do you participate in? _____

4. **Please list any difficulties you experience with your appetite or eating patterns:** _____

   _____

5. **Are you currently experiencing overwhelming sadness, grief, or depression?** ☐ **Y** ☐ **N**

   If yes, for approximately how long? _____

6. **Are you currently experiencing anxiety, panic attacks, or have any phobias?** ☐ **Y** ☐ **N**

   If yes, when did you start experiencing this?_____

7. **Are you currently experiencing any chronic pain?** ☐ **Y** ☐ **N**

   If yes, please describe: _____

8. **Do you drink alcohol more than once a week?** ☐ **Y** ☐ **N**

9. **How often do you engage in recreational drug use?**
   ☐ **Daily** ☐ **Weekly** ☐ **Monthly** ☐ **Infrequently** ☐ **Never**

10. **Are you currently in a romantic relationship?** ☐ **Y** ☐ **N, if yes, for how long?** _____
    On a scale of 1 – 10, how would you rate your relationship? _____

11. **What significance life changes or stressful events have you experienced recently?** _____

    _____

    _____

    _____

ADDITIONAL INFORMATION:

1. **Do you consider yourself to be spiritual or religious?** ☐ **Y** ☐ **N** **If yes, describe your faith or belief:**

   _____

   _____

2. **What do you consider to be some of your strengths?** _____

   _____

   _____

3. **What do you consider to be some of your weaknesses?** _____

   _____

   _____

   _____

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PRESENT ISSUES AND GOALS:

Are you currently experiencing any suicidal thoughts? ☐ Y ☐ N Have you experience suicidal thoughts in the past? ☐ Y ☐ N
Have you attempted suicide in the past? ☐ Y ☐ N Are you currently experiencing any violent or homicidal thoughts? ☐ Y ☐ N

Please describe why you are coming to counseling (i.e., what are your issues, problems, symptoms, how long has the issue existed, precipitant, etc. Use the back if necessary.):

_____

_____

_____

What are your 2 most important goals for therapy?

1. _____
2. _____

Check any of the following symptoms or problems that you currently are or recently have experienced:

List 1	List 2	List 3	List 4
☐ Stress	☐ Marital Problems	☐ Compulsive Behaviors	☐ God/Faith
☐ Anxiety	☐ Other Relational Problems	☐ Seeing Things Others Don't	☐ Family
☐ Panic	☐ Physical Abuse	☐ Hearing Voices	☐ Church/Ministry
☐ Depression	☐ Emotional Abuse	☐ Racing Thoughts	☐ Children
☐ Apathy	☐ Verbal Abuse	☐ Eating Problems	☐ Work/Career
☐ Fatigue/Lack of Energy	☐ Sexual Abuse	☐ Drug Use	☐ Divorce/Separation
☐ Loss of Appetite/Overeating	☐ Sexual Problems	☐ Alcohol Use	☐ Spiritual Problems
☐ Trouble Sleeping	☐ Gender Identity Issues	☐ Pregnancy	☐ Past Hurts
☐ Poor Concentration	☐ Anger	☐ Abortion	☐ Parents
☐ Feeling Worthless	☐ Aggressive Behavior	☐ Legal Matters	☐ Disabled
☐ Recent Death	☐ Bad Dreams	☐ Work Stress	☐ Child/Custody
☐ Grief	☐ Unwanted Memories	☐ Career Choices	☐ In-laws
☐ Chronic Pain	☐ Loss of Control	☐ Indecisiveness	☐ Aging/Dependency
☐ Loneliness	☐ Impulsive Behavior	☐ Parenting Problem	☐ School/Learning
☐ Fears	☐ Controlling	☐ Financial Problems	☐ Being Single
☐ Shyness	☐ Controlled by Others	☐ Spiritual Problems	☐ Pre-marital
☐ Low Self-Esteem	☐ Obsessive Thoughts	☐ Other Addictions	☐ Other

Please use an "X" on the scale below to indicate how distressing your problem(s) are to you.

1_____**5**_____**10**