

The Biblical Counseling Center

INTAKE (SINGLES) FORM

PERSONAL INFORMATION

Name _____ E-mail _____

Street Address _____

City _____ State _____ Zip _____

Sex _____ Birth Date _____ Age _____ Weight _____ Height _____

Home Phone _____ Cell Phone _____ Business Phone _____

Occupation _____

Marital Status (check one)

Single Divorced Widowed Other _____

Education: Last completed grade (prior to college) _____

Other Education: (List type and years) _____

I was referred to The Biblical Counseling Center by _____

PREVIOUS RELATIONSHIP AND FAMILY INFORMATION

Name of Former Spouse: _____ Address: _____

Telephone: _____ Occupation: _____ Bus Phone: _____

Former Spouse's Age _____ Education (in years) _____ Religion _____

Are you in contact with your former spouse? Yes No

Had you ever been separated before being divorced or widowed? Yes No

If "yes", when? From _____ To _____

If divorced, who filed? _____ What was your reason for divorce? _____

Date of Marriage _____ Your ages (when married) Husband _____ Wife _____

How long did you know your spouse before marriage? _____

Length of steady dating with spouse _____ Length of engagement _____

Give brief information about any previous marriages before the one listed above:

Husband _____

Wife _____

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Children's Names	Age	Gender	Living yes no	Education (in years)	Marital Status	From a previous marriage? (√)

Were you raised by anyone other than your own parents? Yes No

If "yes," please explain: _____

How many older siblings do you have? _____ Brothers _____ Sisters _____

How many younger siblings do you have? _____ Brothers _____ Sisters _____

RELIGIOUS BACKGROUND

What church do you currently attend? _____

Are you a member? Yes No Denominational Preference _____

Church Address _____

Pastor's Name _____ Pastor's Phone _____

Is your pastor aware of you coming to the Biblical Counseling Center? _____

Would it be your desire that we contact your pastor for information and help? Yes No

Church attendance per month (**circle one**) ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩+

Church attended in childhood _____

Have you been baptized? Yes No When? _____

Do you consider yourself to be a religious person? Yes No

Do you believe in God? Yes No Uncertain

Do you pray to God? Yes No Uncertain

Have you come to the place in your spiritual life where you can say that you know for certain that if you were to die today you would go to heaven? Yes No Uncertain

If "yes," what is the basis of your certainty? _____

How do you characterize your relationship to Jesus? None Struggling Growing Strong

How often do you read the Bible? Never Seldom Often

Describe any recent changes in your spiritual life _____

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PERSONALITY INFORMATION

Have you had any biblical counseling before? Yes No
 Have you had any psychotherapy before? Yes No

Counselor's Name	Dates (Month & Year)	Medication Prescribed	Diagnosis Outcome
	From To		
	From To		
	From To		

Please check any of the following words that would describe you:

- | | | |
|-------------------------------------|---|---|
| <input type="checkbox"/> Ambivalent | <input type="checkbox"/> Self-confident | <input type="checkbox"/> Persistent |
| <input type="checkbox"/> Ambitious | <input type="checkbox"/> Hardworking | <input type="checkbox"/> Impatient |
| <input type="checkbox"/> Nervous | <input type="checkbox"/> Moody | <input type="checkbox"/> Active |
| <input type="checkbox"/> Impulsive | <input type="checkbox"/> Excitable | <input type="checkbox"/> Imaginative |
| <input type="checkbox"/> Often-blue | <input type="checkbox"/> Serious | <input type="checkbox"/> Serious |
| <input type="checkbox"/> Calm | <input type="checkbox"/> Shy | <input type="checkbox"/> Good-natured |
| <input type="checkbox"/> Easy-going | <input type="checkbox"/> Extrovert | <input type="checkbox"/> Likeable |
| <input type="checkbox"/> Introvert | <input type="checkbox"/> Quiet | <input type="checkbox"/> Hard-boiled |
| <input type="checkbox"/> Leader | <input type="checkbox"/> Sensitive | <input type="checkbox"/> Hypersensitive |
| <input type="checkbox"/> Submissive | <input type="checkbox"/> Self-conscious | <input type="checkbox"/> Lonely |
| <input type="checkbox"/> Suspicious | | |

Please check the appropriate response:

- | | | |
|---|------------------------------|-----------------------------|
| Have you ever felt people were watching you? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever had hallucinations? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you sometimes unable to judge distances? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you afraid of being in a car or airplane? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is your hearing exceptionally good? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Approximately how many hours sleep do you get each night?

When do you usually: Go to sleep? _____ Fall asleep? _____ Get out of bed? _____

HEALTH INFORMATION

Rate your health: Excellent Good Average Declining Other

Describe any recent weight changes? _____

List all important present or past illnesses, injuries and handicaps _____

Do the above limit you in any way? Yes No; If Yes, how? _____

Date of last medical exam: _____ Report: _____

