

Date received \_\_\_\_\_

**Intake Form**  
**Park Cities Presbyterian Church Counseling Network**

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address \_\_\_\_\_ Phone (h) \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ Phone (w) \_\_\_\_\_  
Email address \_\_\_\_\_ Phone (c) \_\_\_\_\_  
When & where do you prefer to be reached? \_\_\_\_\_ Message okay? \_\_\_\_\_

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Current Marital Status: Single \_\_\_\_ Engaged \_\_\_\_ Married \_\_\_\_ Separated \_\_\_\_ Divorced \_\_\_\_ Widowed \_\_\_\_  
Date of Current Marriage/ Separation \_\_\_\_\_ Number of Marriages \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Number of Children and Ages \_\_\_\_\_  
Emergency Contact: Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship to you \_\_\_\_\_

Who Currently Lives in Your Home? (Please include yourself):

Name	Relationship to You	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who referred you, or how did you hear about us? \_\_\_\_\_

Please indicate specific days and times for your appointment availability:

Monday \_\_\_\_\_ Tuesday \_\_\_\_\_ Wednesday \_\_\_\_\_ Thursday \_\_\_\_\_ Friday \_\_\_\_\_

What type of counseling would you like?  Individual  Pre-Marital  Marital  Family  Relationship  
Counselor Preference (if any) \_\_\_\_\_

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**REASONS FOR SEEKING HELP**

What concerns have led you to pursue counseling? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Where are your concerns causing the most problems for you? Check all that apply:

Home  Work  Marriage  Other Relationships  God

When did your present concern become a problem for you? \_\_\_\_\_

Have any concerns about you been identified by others? \_\_\_\_\_

Please rate the severity of your present concerns on the following scale (check one):

Mild  Moderate  Severe  Totally Incapacitating

Date received \_\_\_\_\_

**MEDICAL/ HEALTH INFORMATION**

How would you rate your current physical health?  Excellent  Good  Fair  Poor

Date of last physical examination: \_\_\_\_/\_\_\_\_/\_\_\_\_

Are you currently experiencing any physical problems? (e.g. headaches, body aches, stomach problems)  Yes  No

If yes, please explain: \_\_\_\_\_

MEDICATION(S) Over-the-counter or prescription	DOSAGE

Previous hospitalizations for medical reasons: Date: \_\_\_\_\_ Reason: \_\_\_\_\_

Date: \_\_\_\_\_ Reason: \_\_\_\_\_

Have you ever been hospitalized for psychiatric purposes?  Yes  No

If yes, please explain including name of hospital, location, and dates: \_\_\_\_\_

Please list names of any previous counselors or therapists, including dates and contact number: \_\_\_\_\_

Please list any previous pastoral counseling, including dates and pastor's name \_\_\_\_\_

How do you feel about the results of your previous counseling? \_\_\_\_\_

What do you hope to gain from counseling? \_\_\_\_\_

**OCCUPATIONAL/ EDUCATIONAL INFORMATION**

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Annual income (optional): \$ \_\_\_\_\_

If Currently a Student: Field of Study \_\_\_\_\_ Part-Time  Full-time

Institution, College, or University \_\_\_\_\_

What is the highest level of education that you have completed?  Did not graduate high school  high school/ GED

some college  Associate's degree  Bachelor's degree  Master's degree  Professional degree  Doctoral degree

Are you a member of PCPC?  Yes  No If yes, are you a member in good standing?  Yes  No

Are you a member at another church? \_\_\_\_\_

Please describe the type of support that you currently have (friends, family, etc.): \_\_\_\_\_

Who are the people who know you the best? \_\_\_\_\_

**FOR OFFICE USE ONLY**

Notes: \_\_\_\_\_

Follow-up:  Yes  No Date: \_\_\_\_\_

Referred to: \_\_\_\_\_