TPC
Integrative Psychotherapy & Pastoral Counseling

CONFIDENTIAL INTAKE

Please fill out this information form as carefully and as thoroughly as possible. This information will be confidentially used by your therapist.

GENERAL INFORMATION

_____ _____
Name Age & DOB (mm/dd/yyyy)

_____
Name of Parent(s)/Guardian(s) if under 18

_____ ☐ Home ☐ Mobile ☐ Work ☐ Other
Phone Number

_____
Email Address

_____
Address City State Zip Code

_____
Emergency Contact Relation to Client Phone Number(s)

Referral Source: ☐ Clergy ☐ Former Client ☐ Friend/Family ☐ Mental Health Agency
☐ Physician ☐ Therapist/Psychiatrist ☐ Educator ☐ TPC Website
☐ Psychology Today ☐ Insurance Co. ☐ Other: _____

_____
Referrer's Name

Permission to contact referral source *(please initial)*: ☐ Yes _____ ☐ No _____

EDUCATIONAL INFORMATION

Highest level of schooling completed: ☐ High School ☐ College ☐ Graduate
☐ Professional training ☐ Currently a student, grade: _____ ☐ Other: _____

Names of College/University/Technical/Business School(s) attended:

_____

Diploma/Degree/Certificate(s) achieved: _____

Further study plans: _____

OCCUPATIONAL INFORMATION

Employment status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Retired ☐ Receive Disability
☐ Other: _____

Place of Employment: _____ Length of Employment: _____

Position/Title: _____ Salary: _____

Previous Job/Career(s): _____

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FAMILY INFORMATION

Relationship Status: ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☑ Widow(er)
☐ Committed Partnership Date of Same: _____
Name of Spouse/Partner: _____
State length of any previous marriage(s) and if they ended by divorce or death and when:

_____

_____

Parents: *Mother* ☐ Living (age ____) ☐ Deceased (date _____)
Father ☐ Living (age ____) ☐ Deceased (date _____)
Siblings: Number of Brothers _____ Number of Sisters _____ ☐ Only Child
Children: Please list Name(s), Age(s), By Present Marriage (P), Former Marriage (F), Adopted (A) and whether they live at home:

_____

_____

Others who live with you: _____

Any children deceased? _____

If so, how and when: _____

Was your parents' marriage: ☐ Happy ☐ Average ☐ Unhappy

Was your home impacted by: ☐ Separation ☐ Divorce ☐ Death ☐ Other: _____

If yes, how old were you? _____ With whom did you subsequently live? _____

RELIGIOUS INFORMATION

Do you consider yourself a religious/spiritual person? ☐ Yes ☐ No

Religious preference: _____

Religious background of family: _____

Your congregation: _____

Name of religious leader: _____

Has there been a noticeable or significant change in your spiritual life recently? Describe:

_____

_____

HEALTH

Name, Address & Phone Number of current Primary Care Physician (PCP):

_____

Would you like coordinated treatment planning with your provider?
☐ Yes (release required) ☐ No

List any health issues, illnesses, disabilities, and/or allergies:

_____

_____

Surgeries/Accidents (include dates): _____

_____

Were you ever hospitalized? ☐ Yes ☐ No How many times? _____

At what age(s)? _____ For how long? _____

Reason(s): _____

Current Medications:

Medication Name	Dosage	Frequency	Start Date	Prescribing Physician

What is your alcohol use on average?
☐ None ☐ Less than 1-2x week ☐ 3-5x week ☐ 6-7x week

What is your cannabis/drug use on average?
☐ None ☐ Less than 1-2x week ☐ 3-5x week ☐ 6-7x week

What is your pornography use on average?
☐ None ☐ Less than 1-2x week ☐ 3-5x week ☐ 6-7x week

Have you ever received psychotherapy, counseling, or other treatment for personal and/or family problems? ☐ Yes ☐ No
When? _____

Concerns Explored: _____

_____

Name, Address & Phone Number of Mental Health Professional consulted:

_____

IMPORTANT QUESTIONS FOR YOU AND YOUR THERAPIST

Please described your reasons for seeking help. How do you think therapy would be beneficial?

_____

_____

How long have you been aware of the problem(s)? _____

Who else knows about your problem(s)? _____

If you are seeking family/couples therapy, do you think your family member/partner would answer these questions differently? _____

If so, how? _____

_____

My greatest fear is: _____

My greatest hope is: _____

Please circle any areas in which you have concerns or you feel apply to you:

Anxiety	Elevated mood	Judgment errors	Regrets
Anger	Empty feelings	Lonely	Relationship problems
Alcohol/Substance use	Fatigue	Loss of faith	Self-esteem problems
Bored	Financial problems	Loss of meaning in life	Sexual addiction
Cannot make decisions	Grief	Misunderstood	Sexual difficulties
Childhood abuse	Guilt	Mood swings	Sleep problems
Confused	Headaches	Muscle tension	Suicidal/Self-Harm thoughts
Controlling	Hopelessness	Nightmares	Trauma history
Depressed	Identity issues	Pain	Worry
Distractible	Impulsivity	Panic attacks	Other:
Disturbing thoughts	Internet addiction	Phobias/fears	
Eating problems	Irritable	Poor concentration	