

METHODIST COUNSELING AND CONSULTATION SERVICES
CLIENT INTAKE FACE SHEET

Date of Initial Visit _____ Social Security No. _____ - _____ - _____

First Name _____ MI _____ Last Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone () _____ Okay to leave message? Yes No

Work Phone () _____ Okay to leave message? Yes No

Cell Phone () _____ Okay to leave message? Yes No

Email _____

RELATIONSHIP STATUS: Single; Committed; Engaged; Married; Separated; Divorced; Widowed

If married, years married _____ Spouse's Name _____

Names/Ages of Children _____

Previous Marriage(s)? Yes No If yes, dates(s): From _____ to _____; From _____ to _____

If separated, divorced, or widowed, years/months separated _____ divorced _____ widowed _____

If single, do you have a significant relationship? Yes No Significance _____ How long? _____
(boyfriend, girlfriend, partner, etc.)

Names/Ages of Siblings: _____

Recent deaths of family/friends (Relation/dates) _____

Person Responsible for Payment _____ Type of Counseling: Individual; Couple; Family; Group

DEMOGRAPHIC INFORMATION

Racial/Ethnic Identity: African-American Asian Caucasian Hispanic Native American Other _____

Religious Preference _____ Local Congregation _____

Who referred you to our Center? _____

Emergency Contact Person _____ Telephone _____

EDUCATION

Grade Completed (Circle One) 1 2 3 4 5 6 7 8 9 10 11 12 High School Diploma? Yes No

College 1 2 3 4 Name of College _____ Degree(s) _____

Graduate School 1 2 3 4 Name of School _____ Area of Study _____

Business/Technical School _____ Course of Study _____

(Continued on the back)

EMPLOYMENT DATA

Employer _____ Length of Employment _____

Type of Work You Do _____

HEALTH DATA

List current illness(es) or symptoms _____

List any major surgeries, serious crises, losses, or handicaps (with dates) _____

Last medical exam (date) _____ Reason _____

Name and Address of Physician _____

Have you ever received counseling or other treatments for personal, marital, or family problems? Yes No

Dates _____ Name of Professional (Dr., agency, pastor, etc.) _____

Substances used _____

Current medications (and doses) _____

Please describe your reason(s) for seeking help _____

What would you like to have happen for you as a result of pastoral counseling? _____

FOR OFFICE USE ONLY

Center (Charlotte) Terry Bldg Blair Road UMC University City UMC Dilworth UMC

(Other) Hickory Statesville Monroe Gastonia Shelby

Therapist _____ Full time Part time Intern

Agreed upon fee _____ Diagnosis (DSM-IV) _____

Referred by: Self Clergy Physician Attorney Social Agency School Personnel Court Order

Other Counselee Brochure Yellow Pages Website Other _____

Length of visit: Half Hour Hour Hour and Half Two Hours