INTAKE COUNSELING INFORMATION SHEET

Date: _____

Name: _____ Age: _____

Phones: Day _____ Evening _____

Address: _____

City: _____ State: _____ Zip: _____

Marital Status: _____ How long: _____ Spouse's name: _____

Children:

Name	Age	Name	Age

1. Who is Jesus Christ?
   _____
2. Who is Jesus Christ to you?
   _____
3. Have you accepted the gift of salvation? Yes_____ No _____
   If yes, date _____
4. Who referred you to this program?
   _____
5. For what are you seeking help?
   _____
   _____
   _____
   _____
6. When did these symptoms start?
   _____
   _____
7. Have you ever had counseling before? If so, what for and where?
   _____
   _____
8. Are you taking any medications now? Please list dosage, purpose and physician.
   _____
   _____
   _____

9. Does you mind sometimes race so fast that no one can keep up with you?

10. What do you do with frustration?

11. Do you ever go on spending binges to deal with your frustration? (If yes, how much do you spend?

12. Do you ever lose track of large chunks of time and have no idea what you were doing?

13. Do people react to you as if you make no sense?

14. Do you ever have repetitive, strange, intrusive thoughts? If yes, describe.

15. Do you ever feel like you lose contact with reality?

16. Do you often feel so much energy you can't sleep for days?

17. Are other people ever irritated by your excessive rapid speech?

18. Do you ever feel you're going all to pieces?

19. Do you ever do things that cause you trouble? (If so, what?)

20. Do your moods fluctuate wildly?

_____
_____
_____
_____

21. Is there any additional information you would like the Minister to know?

_____
_____
_____
_____