Abiding Hope Christian Counseling, Ltd.
19115 FM 2252 Ste. 12
San Antonio, TX 78266
Office phone: 210-236-7768
www.abidinghopecc.com

INTAKE FORM

PLEASE PRINT

TODAY'S DATE: _____ **HOME PHONE: _____**

NAME: _____CELL: _____

ADDRESS:
_____D.O.B._____

CITY, STATE, ZIP: _____STATUS: S M D W

E-Mail address:_____

REFERRED BY: _____

Are you comfortable with the therapist praying at the end of each session? _____

Briefly list the reason for your visit?

_____

_____

_____

_____

Are you currently feeling suicidal? _____ if so, do you have a plan? _____

Have you recently been hospitalized for suicidal ideations? _____

Has anyone in your family completed suicide? If YES, who and when:

_____

Do you cut or do any other self-harm behaviors?

_____

Have you ever been under the care of a psychiatrist or therapist?
Yes_____No_____ If yes, with whom and what was the nature of the treatment?

_____

_____

Are you currently under the care of a psychiatrist or therapist?

Yes____No_____ If yes, with whom and what is the nature of the treatment? _____
_____

Have you received any psychological testing? _____
_____

Do you currently have a physician? _____**If so, complete authorization form on page 10.**

Do you use alcohol or other drugs on a regular basis and if so, how often?
_____

BRIEF MAST

1. Do you feel you are a normal drinker? Yes_____No_____

2. Do friends or relatives think you are a normal drinker? Yes_____No_____

3. Have you ever attended a meeting of Alcoholics Anonymous (AA)? Yes_____No_____

4. Have you ever lost friends or girlfriends/boyfriends because of drinking? Yes_____No_____

5. Have you ever gotten into trouble because of drinking? Yes_____No_____

6. Have you ever neglected your obligations, your family, or your work for two or more days in a row because of drinking? Yes_____No_____

7. Have you ever had delirium tremors (DT's), severe shaking, heard voices or seen things that weren't there after heavy drinking? Yes_____No_____

8. Have you ever gone to anyone for help about your drinking? Yes_____No_____

9. Have you ever been in a hospital because of drinking? Yes_____No_____

10. Have you ever been arrested for drunk driving or driving after drinking? Yes_____No_____

Have you recently experienced of any losses such as: a death of a loved one, miscarriage, loss of a job, house fire, loss of hopes or dreams, such as wanting more children?_____

_____

_____

Have you ever experienced trauma such as domestic violence (even as a witness), sexual abuse, sexual assault, war, car accident: _____

_____

_____

Have you recently been diagnosed or treated for a severe or long-term illness:

_____

_____

_____

Are you presently taking medication? _____ If so, what?_____

_____

_____

_____

How have you been affected by the pandemic? _____

_____

_____

_____

Headaches	Dizziness	Fainting spells	Palpitations
Stomach trouble	Poor/no/excessive appetite	Weight loss/gain	Bowel troubles
Excessive sweating	Trouble falling asleep	Fitful sleep	Nightmares
Early morning awakening	Hate to get up	Bad home/living conditions	Financial problems
Disbelief in God	Changed value system	Not living up to religious obligations	Quick to anger
Crisis of faith/identity	Conflict with authority	Spiritual problems	Fear of dying/losing mind/having cancer
Change mind often	Uncontrollable outbursts	Frequent job changes	Find praying meaningless
Unpredictable moods	Very selfish	Unstable	Hard to deny self
Indecisive	Feel helpless	Thoughts of death/suicide	Impulsive behavior
Compulsion to do certain things	Hard/unable to make friends	Hopeless	Obsessive thoughts
Guilty	Depressed	Worthless	Ashamed
Afraid of people	Fear of hurting one's feelings	Eager to please	Shy
Sexual problems	Unloved	Scrupulous	Feel inferior
Unable to have good time	Fussy	Don't care about anything	Inadequate
Worried	Don't like weekends/vacations	Can't sit still	Perfectionist
Feel tense	Unable to relax	Lonely	Panicky

Tremors	Alcoholic	Smoke pot	Fearful
Overly suspicious	Personality change	Driven	Drink more than socially
Forgetful	Disoriented	Anxious	Strange sensations
Confused	Use drugs	Hard to concentrate	Blackouts
Take sleeping pills	Tired	Exhausted	Memory loss

How would you describe your present health? (Excellent, good, fair, poor)

A. Physical_____

B. Emotional_____

C. Spiritual_____

Circle any of the following that apply to you:

Other symptoms not mentioned above:

_____

_____

_____

_____

Marriage:

Currently married/divorced/single

Spouse: _____Age: _____

Year married: _____How many pregnancies? _____

How many live births? _____Loss due to? _____

Were pregnancies natural or was IVF used? _____

Children: (list names and ages):_____

_____

Describe marriage_____

_____

_____

Any previous marriages by you or your spouse? _____

_____

Has there ever been an infidelity? _____

Issues with pornography? _____

Are you currently sexually active? _____

Finances:

Current occupation?

_____

Have you recently lost a job? _____

Have you ever lost a job or business? _____

Any financial problems at present? _____

_____

Have you ever been arrested?

_____

Current legal problems? _____

_____

Military service? _____

Childhood:

Names of parents & siblings:

_____

_____

Are they living? _____

Is there any family history of mental or emotional illness? _____
_____
_____

Briefly describe what it was like growing up in your home_____
_____
_____
_____
_____
Describe discipline used in your home/who enforced it? _____
_____
_____
_____
_____

Was mother's pregnancy (with you) & delivery normal? Any complications? Were all developmental milestones (walking, talking, and toilet training) met at normal times? Normal childhood diseases?
_____
_____
_____
_____

Any hospitalizations, trauma (including sexual or physical abuse) while growing up?
_____
_____
_____

Any outstanding memories (positive or negative) regarding elementary, middle, or high school?
_____
_____
_____

Highest grade completed_____

Any learning disabilities? _____

What are your ambitions/goals?

_____

_____

What do you consider your greatest assets/strengths/talents/capabilities?

_____

_____

What do you consider your weaknesses? _____

_____

What have the three greatest obstacles in life been? _____

_____

_____

_____

Do you have any hobbies or interests?

_____

_____

_____

How is most of your free time occupied? _____

_____

_____

Does your present way of life and work satisfy you? _____

_____

_____

In what way of life/work do you think you would be happiest? _____

_____

_____

_____

Who are your current friends? _____

_____

_____

What is the role of religion/spirituality/church in your life, both past and present?

_____

_____

_____

_____

Denomination? _____

Anything else that I should know? _____

_____

_____

_____

_____

_____

_____

Abiding Hope Christian Counseling
Christina Ashby, LCSW Clinical Director
19115 FM 2252 Ste. 12, San Antonio, TX 78266

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION

I hereby authorize Christina Ashby, LCSW and Abiding Hope Christian Counseling, to disclose the individually identifiable health information as described below, which may include psychotherapy notes. I understand that if I do not sign this form, federal and state law will prohibit Ms. Ashby and her practice from releasing records regarding her treatment of me/my child to the designated Recipient. By accepting the records pursuant to this Authorization, the Recipient acknowledges that the protected health information covered by this release is confidential, privileged and protected by federal and state privacy statutes and regulations, and agrees that Ms. Ashby's release of the individually identifiable health information will continue to be protected by federal and state privacy statutes and regulations.

_____
Print Patient Name Date of Birth Social Security Number

Date(s) of service (if known): _____

Description of information to be released: (check all that apply)

____ Entire Record _____ Evaluation Reports
_____ Billing Records _____ Consultation Notes
_____ Psychotherapy Notes _____Other_____

Description of the purpose of the use and/or disclosure:

_____
_____

The individually identifiable health information described herein shall be released to:
[INSERT NAME AND ADDRESS OF DESIGNATED RECIPIENT]

I intend for this Authorization to remain in full force and effect until I revoke it in writing. Further, it is my intent that a copy of this Authorization shall have the same effect as the original.
I further understand that I may revoke this authorization at any time by notifying Christina Ashby, LCSW in writing at Abiding Hope Christian Counseling, 19115 FM 2252, Suite 12, San Antonio, TX 78266. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____
Signature of Client or Client's Representative Date

_____
Printed Name of Client or Client's Representative

_____ or _____
Relationship to Client Legal Authority (attach supporting documentation)