Abiding Hope
Christian Counseling

McKenzie Woods, MEd LPC
certified TF-CBT
19115 FM 2252 Ste. 12
San Antonio, TX 78266
Voice mail: 210-504-7611
www.abidinghopecc.com
mwoodslpc@gmail.com

ADULT INTAKE FORM:

(Please Print and fill out before first session)

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?_____

_____

_____

_____

_____

Current occupation?_____

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

A. Physical_____

B. Emotional _____

C. Spiritual_____

Are you currently sexually active?_____

Marriage: Currently married/divorced/single

Spouse:_____Age:_____

Occupation:_____Year married _____

Children (list ages):_____

_____

_____

_____

Describe marriage_____

_____

_____

_____

Any previous marriages by you or your

spouse?_____

_____

Any financial problems at present _____

_____

_____

Legal problems?_____

_____

Ever arrested?_____

Military service?_____

_____

Do you have any hobbies or interests?_____

_____

_____

Who are your friends now?_____

_____

_____

Circle any of the following that apply to you:

Headaches	Dizziness	Fainting spells
Palpitations	Perfectionist	Worthless
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	Take sleeping pills	Tired
Confused	Disoriented	Anxious
Forgetful	Memory loss	Strange sensations
Overly suspicious	Personality change	Blackouts
Tremors	Drink more than just socially	Alcoholic
Use drugs	Smoke pot	Ashamed
Don't like weekends/vacations	Compulsion to do certain things	
Feel tense	Fearful	Lonely
Panicky	Hard to concentrate	Exhausted
Worried	Unable to relax	Can't sit still
Unable to have good time	Don't care about anything	Fussy
Scrupulous	Obsessive thoughts	Driven
Sexual problems	Feel inferior	Inadequate
Unloved	Shy	Hard/unable to make friends
Afraid of people	Fear of hurting one's feelings	Eager to please
Indecisive	Change mind often	Depressed
Feel helpless	Hopeless	Guilty
Thoughts of death/suicide	Fear of dying/losing mind/having cancer	
Very selfish	Impulsive behavior	Unpredictable moods
Unstable	Quick to anger	Uncontrollable outbursts
Hard to deny self	Conflict with authority	Frequent job changes
Bad home/living conditions	Financial problems	Spiritual problems
Disbelief in God	Changed value system	Crisis of faith/identity
Not living up to religious obligations		Find praying meaningless

Other symptoms not mentioned above:

_____

_____

_____

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

_____

_____

_____

_____

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 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____

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, 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? _____

_____

_____

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?_____

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

Denomination? _____

Anything else that I should know?_____

_____

_____

_____

_____

_____

_____