CHANGE OF HEART COUNSELING, LLC

25 Merchants Way ~ Colts Neck, NJ 07722

www.changeofheartcounselingnj.com 732.996.9797

Client Intake Form

The information contained below is to allow us to understand you and your reasons for requesting counseling and to help you more expediently. Please fill out all forms as completely as possible. All information is held in the strictest confidence and cannot be divulged to anyone without your written consent.

Personal Information

Name____ Date_______________________

Name of parent or guardian (if under 18years) ____

Date of Birth ______________________________ Gender (Circle one): M F Age____________

Address____

City ____ State____________________ Zip _________________

Home Phone ____ May we leave a message? Yes____ No _____

Cell Phone ____ May we leave a message? Yes____ No _____

Email Address ____ May we email you? Yes ____No _____

*Please note: email correspondence is not considered to be a confidential medium of communication.

Referred by: (If applicable) ____

Marital Status (Circle one): Single Married Divorced Separated Widow(er) Cohabitating

Spouses' Name____ Length of Marriage______________________

If previously married; please give approximate dates, how many times, and how dissolved_________________________

____

____

Briefly describe your relationship with your spouse: (If not married; your parents, boyfriend, girlfriend, etc.)

____

____

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Do you have children? ________ How many? ________________ How many living at home? __________________

How many children in your home from previous marriage? ____

LIST NAMES OF CHILDREN	AGE

Family History

Father's Name____ Living/Deceased? _______________________

His current age_________ Last saw him: ____

Mother's Name____ Living/Deceased? _______________________

Her current age________ Last saw her: ____

Was your parental home ever impacted by the following?

Death_______ Your age at the time____________ How were you effected? __________________________________

____

Divorce ______ Your age at the time_____________ How were you effected? ________________________________

____

Separation_____ Your age at the time___________ How were you effected? __________________________________

____

Desertion______ Your age at the time __________ How were you effected? _________________________________

____

Did you have a good or bad relationship with your;

Father___________ Explain: ____

____

Mother__________ Explain:____

____

Brothers/Sisters____________ Explain: ____

____

Was Parental family a close-knit family? ____________ Is it close now? _________________________

Did your family change residences often? ______________ Why? ____

What is your birth placement in your family? (Circle one): 1 2 3 4 5 6 7 8 9 10

Are you adopted? ______________________ Are any brothers and sisters adopted? _________________________

Education

What is the highest grade you completed in school? ____

What is your highest degree earned? (Circle one):

AA BA/BS MA/MS Other____

Occupation

Your Occupation____ How Long? __________________

Employer: ____

What type of work do you do? ____

Do you enjoy your work? _____________________ Is there anything stressful about your current job?

____

Spouse's occupation____

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If you could be anything or anyone you wanted, who or what would you be? (Please be specific)

____

____

Personal History

How old were you when you left parental home? ___________

Religion/Spiritual belief system raised in (if any): ____

Do you believe in God? ____

Religious Affiliation? ____

Do you attend Religious Services? _________ How often? ____

How do you see God/Higher Power/ Spirituality being utilized in your recovery? ________________________________

____

Presently I believe my SPIRITUAL condition is: (Circle one)

Poor Fair Average Good Excellent

Presently I believe my PHYSICAL condition is: (Circle one)

Poor Fair Average Good Excellent

Presently, I believe my EMOTIONAL condition is: (Circle one)

Poor Fair Average Good Excellent

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General Health Information:

How many times a week do you currently exercise? ____

Please list any difficulties you experience with your appetite or eating patterns:

____

Are you currently experiencing any chronic pain? Yes______ No______ Please explain: _________________________

____

How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Check the items that best describe or relates to the reason you are seeking counsel:

Bereavement	Religious doubts	Relationship with parents
Depression	Marriage problems	Relationship with children
Hatred	Bitterness	Relationship with others
Anxiety	Sexual concerns	Loss of Faith in God
Nervousness	Adultery	Loss of faith in self
Fear	Impotency	Loss of faith in others
Self-doubt	Frigidity	Loss of hope
Guilt	Homosexuality	Loss of meaning
Suicidal	Anger	Loss of feeling or thoughts
Loneliness	Loss of love	Loss of self-respect
Other:		

Have you previously received any type of counseling (psychotherapy /psychiatric services) before?

Yes ____ No_____ If so, when____

Name of practitioner: ____

What was the outcome? ____

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Are you currently on any prescription or over the counter medication? Yes_____ No_____

Please list:

______________________________ ________________________________ _________________________________

______________________________ ________________________________ _________________________________

______________________________ ________________________________ _________________________________

In the section below identify if there is a family history of any of the following:
(If yes, please indicate the family member's relationship to you in the space provided, i.e.: father, mother etc.

Condition	Please Circle		List Family Member
Alcohol/Substance Abuse	Yes	No	
Anxiety	Yes	No	
Depression	Yes	No	
Domestic Violence	Yes	No	
Eating Disorders	Yes	No	
Obesity	Yes	No	
Obsessive Compulsive Disorders	Yes	No	
Schizophrenia	Yes	No	
Suicide Attempts	Yes	No	

Is there anything we have not covered in this initial intake form your counselor should be aware of that would help in your personal journey to wellness?

____

____

____

What would you like to accomplish out of your time in therapy?

____

____

____

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LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without written consent of the client or the client's legal guardian. Noted exceptions are as followed:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers
Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes types of services, dates/times of services, diagnosis, treatment plan, and description of impairment and progress of therapy.

I agree to the above limits of confidentiality and understand their meanings and implications.

____
Print Name

____ ______________________
Client Signature (clients' Parent/Guardian if under 18) Date