The iHope Christian Care & Counseling Center
1414 W. Evans St., Florence, SC 29501
(843) 702-0323
www.ihopeflorence.com

Client Intake Form   Date ______________

This information is confidential and will not be shared with any third party unless required by law as stated in the Informed Consent.

Client Name: ____
Please print first and last name (Indicate preferred nickname if needed)

Mailing Address: ____

Phone: (H)____________________ (C)____________________ (W)____________________

Email: ____

Preferred Contact Method: ____________________

Where are you comfortable with iHope leave a voicemail? _____home _____cell _____work

May iHope send session reminders via: _____text message _____email _____only by phone call

Date of Birth: _______/_______/_______ Age__________ Gender: ______________

Employer: ______________________________ Occupation: ______________________

Last year of school completed (please circle): 9 10 11 12 GED College Adv. Degree

Marital status: Single Engaged Married Separated Divorced Widowed

Spouse (name and age): ________________________ Years Married: ____________

Children (names and ages): ____

In case of emergency, contact:

Name: ____________________ Relationship: ____________ Phone: ______________

Please sign to give consent for us to contact this person in an emergency: ____________________

REASON FOR COUNSELING

Please briefly explain why you are coming to counseling: ______________________________

____

What do you hope to gain here (how you hope your life will change): ____________________

____

Where do you see these concerns impacting you the most today? (mark all that apply)

Home Work Marriage Children God Other ____________________

INTEGRATION OF FAITH IN THE COUNSELING PROCESS

How important is your faith/spirituality to you? Very Moderate Little Not at all

Are you active in your church? Very Somewhat No I would like to be more active

Church membership/affiliation ____

Do you desire prayer to be any part of the counseling process? Yes No Maybe

MEDICAL AND COUNSELING HISTORY

Physician Name/Contact info: ______________________________ Date of last physical: ______

Current medications (prescription name and dosage): ______________________________

____

Have you been hospitalized in the past 18 months? Yes No *If yes, please indicate the reason and duration of stay:* ______________________________

Have you received therapy/counseling or psychiatric care in the past 2 years? Yes No

If yes, please indicate where, why, and when: ______________________________

Would you be willing for us to talk with your previous provider? Yes No Maybe

Please describe your current physical health:

Sleep: ______________________ Diet: ______________________

Exercise: ______________________ Physical complaints: ______________________

Use of alcohol, tobacco, or drugs: ______________________________

Other physical/medical concerns: ______________________________

AREAS OF CONCERN *(mark all that apply)*:

Depressed mood	Difficulty concentrating	Fear
Anxiety/excessive worry	Difficulty organizing/losing things	Fatigue
Weight/Appetite changes	Feelings of panic	Confusion
Grief	Easily upset/on edge	Finances
Stress	Fear of social situations	Excessive spending
Sleep problems	Excessive use of media/technology	Alcohol and/or drug use
Anger/frustration	Relationships with ____________	Loneliness
Mood swings	Repetitive behaviors	Pornography use
Parenting or Family	Recurrent undesirable thoughts	Gambling
Marital problems	Self-harm	Impulsivity
Sexual problems	Suicidal thoughts or attempts	Career/Job/School
Spiritual problems/faith	Self-Esteem	Other ______________

Is there anything else you'd like to tell us here? ______________________________

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