Redeemer Counseling Services

Adult Intake Form

Name: _____ Sex: ____ Date of Birth: ___/___/_____

Street Address: _____ Phone (h): _____

City, State, Zip: _____ Phone (w): _____

Email Address: _____ Phone (c): _____

For confidentiality, when and where do you prefer to be reached? _____

Current Marital Status: ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced

Date of Current Marriage/Separation: _____ Number of Marriages: _____

Street Address: _____ Phone (h): _____

Spouse's Name: _____ Date of Birth: _____

Number of Children and Ages: _____

Presently living with: ☐ Parents ☐ Spouse ☐ Roommate ☐ Alone ☐ Other: _____

Emergency Contact: Name: _____ Phone: _____ Relationship to you: _____

Who referred you or how did you hear about us? _____ Counselor Preference (*if none, leave blank)*: _____

Please list specific days/times for your appointment availability (check all that apply):

Monday	☐ morning ☐ afternoon ☐ evening	*Tuesday*	☐ morning ☐ afternoon ☐ evening	*Wednesday*	☐ morning ☐ afternoon ☐ evening	*Thursday*	☐ morning ☐ afternoon ☐ evening	*Friday*	☐ morning ☐ afternoon ☐ evening	*Saturday*	☐ morning ☐ afternoon

What type of counseling are you seeking? *Please select one:*

Type	Description	Forms Required
☐ INDIVIDUAL	1-on-1 counseling	1 intake form
☐ FAMILY	2 or more family members	1 intake form per person over 18 yrs. old
☐ RELATIONSHIP	Couples who are dating	1 intake form per person (total of 2 forms)
☐ PRE-MARITAL	Couples engaged or considering it	1 intake form per person (total of 2 forms)
☐ MARITAL	Couples needing marital guidance	1 intake form per person (total of 2 forms)

REASONS FOR SEEKING HELP

What concerns have led you to pursue counseling? _____

Where are your concerns causing the most problems for you? (Check all that apply): ☐ Home ☐ Work ☐ Marriage ☐ Other Relationships ☐ God

When did your present concern begin to be a problem for _____

Have any concerns about you been identified by others? _____

Please rate the severity of your present concerns on the following scale (Check one): ☐ Mild ☐ Moderate ☐ Severe ☐ Totally Incapacitating

Please indicate which of the following areas are currently problems for you (Check all that apply):

- ☐ Under too much pressure/feeling stressed
- ☐ Excessive anxiety or worry
- ☐ Feeling lonely
- ☐ Angry feelings
- ☐ Concerns about finances
- ☐ Feeling "numb" or cut off from emotions
- ☐ Angry outbursts
- ☐ Excessive fear of specific places/objects
- ☐ Difficulty making friends
- ☐ Feeling as if you'd be better off dead
- ☐ Feeling manipulated or controlled by others
- ☐ Difficulty making decisions
- ☐ Loss of interest in sexual relationships
- ☐ Feeling sexually attracted to members of your own sex
- ☐ Concerns about physical health
- ☐ Blackouts or temporary of loss of memory
- ☐ Insomnia (no sleep) or Hypersomnia (sleep all the time)
- ☐ Loss of appetite/increased appetite
- ☐ Lacking self-confidence
- ☐ Issues with food and/or weight
- ☐ Abuse of alcohol and/or non-prescription drugs
- ☐ Delusions
- ☐ Feeling distant from God
- ☐ Hallucinations
- ☐ Inability to concentrate while at school/work
- ☐ Crying spells
- ☐ Nightmares
- ☐ Loss of interest in usual activities/lack of motivation
- ☐ Obsessions or compulsions with specific activities
- ☐ Inability to control thoughts
- ☐ Feeling trapped in rooms/buildings
- ☐ Hearing voices
- ☐ Feeling that people are "out to get you" or that you're being watched

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MEDICAL/HEALTH INFORMATION

How would you rate your current physical health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor Date of last physical examination: ___/___/___

Are you currently experiencing any physical problems? (e.g. headaches, body aches, stomach problems) ☐ Yes ☐ No

If yes, please explain: _____

MEDICATION(S) Over-the-counter or prescription	DOSAGE

Previous hospitalizations for medical reasons: Date _____ Reason _____

Date _____ Reason _____

Have you ever been hospitalized for psychiatric purposes? ☐ Yes ☐ No

If yes, please explain including name of hospital, location and dates:

Permission to contact previous counselor: ☐ Yes ☐ No Please list names of any previous therapists, including dates and contact number:

How do you feel about the results of your previous counseling?

What do you hope to gain from counseling? _____

OCCUPATIONAL / EDUCATIONAL INFORMATION

Occupation: _____ Status: ☐ Full time ☐ Part time

Employer: _____ Present annual income: $ _____

If Currently a Student – Field of Study: _____ Degree: _____

Institution, University or College: _____ Status: ☐ Full time ☐ Part time

How long have you been with the current employer and are satisfied with your job?: _____

RELIGIOUS BACKGROUND

Do you believe in God? ☐ Yes ☐ No Religious Preference: _____

What church do you currently attend? _____ Are you a member of Redeemer Presbyterian Church? ☐ Yes ☐ No

How much influence does your religion have on your day-to-day activity? _____

CONSENT OF RELEASE OF INFORMATION

In the event that a Redeemer Counselor is not available to address the needs of the client, due to scheduling or otherwise, Redeemer Counseling Services is authorized to release all intake information to a referred therapist. The consent for release of information avoids any delays in beginning therapy and insures that the client receives appropriate care.

Signed _____ **Date** _____

Witness _____ **Date** _____

(Required if under the age of 18)

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Application for Reduced Fee

Please submit with proof of income: a recent paycheck stub, or copy of the first page of most recent tax return.

- Fax: 212-252-0649, include: Application & a copy of a recent pay stub or copy of the first page of most recent tax return.
- Email: rcs@redeemer.com, include: Application & a copy of your paycheck or first page of most recent tax return.
- Reduced fees are based on current income. Therefore, fees are adjusted when income changes.
- We recommend all clients call their medical insurance company to inquire about Out-of-Network Insurance Benefits for Mental/Behavioral Health Services.
- Questions? Contact the Services Coordinator at 212-370-0475 x0, or rcs@redeemer.com.

Personal Information

Name: _____ Date: _____

☐ Full-time Work ☐ Part-time Work. Hours per wk: _____ Employer: _____

☐ Full-time Student ☐ Part-time Student ☐ Not Employed School: _____

☐ New RCS Client ☐ Current/Former client, counselor: _____ ☐ Other: _____

Spouse & Family:

Name:_____ Occupation/Status: _____ Employer: _____

Number of Dependents in family: _____ Names and Ages: _____

Annual Income

Please enter **Adjusted Gross Income** (pre-tax) of most recent tax return: $ _____ Year _____

☐ Single Return ☐ Joint Return

Has your employment changed since your last tax return? ☐ Yes ☐ No

If yes, explain: _____

Has your household/family income changed since your last tax return? ☐ Yes ☐ No

If yes, explain: _____

Current Monthly Income: Personal & Spouse Income

Gross monthly wages or salaries (pre-tax) personal income (include severance pay): $ _____

Gross monthly wages or salaries (pre-tax) from spouse: $ _____

Monthly income, other sources (unemployment, rental property, SSI, SSDI, stocks, bonds, trust fund): $ _____

Gross Monthly Family/Household Total: $ _____

Savings & Assets (Not including real-estate or retirements funds)

Do you have a savings account, stocks (matured/vested), bonds, mutual funds or a trust fund? ☐ Yes ☐ No

If so, what is the value: ☐ below $50,000 ☐ $50,000 - $199,999 ☐ $200,000 - $499,999 ☐ $500,000+

Comments & Additional Information

Is there any additional information you would like us to consider?

Signed: _____ Date: _____