

TRBC Pastoral Care-Intake Form

Today's Date: _____

URGENT MATTER IF CHECKED PLEASE CALL: TODAY WITHIN 48 HOURS

Name: Birth Date:	Presenting Issue:
Age:	Service Required: IND FAM CPL
Home Address (please include city & state)	Have you ever been hospitalized for: Psychiatric Treatment _____ Date _____ Drug Treatment _____ Date _____ Alcohol Treatment _____ Date _____
Email Address/Consent to use Email: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Contact Information Home: Work: Cell: Best way to contact you:	Are you currently having any suicidal thoughts? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please describe their nature and frequency.
Marital Status: ___ M ___ S ___ D	Where do you attend church and for how long? Have there been significant changes in your recent spiritual life? Yes _____ No _____
# of children	Do you have a counselor preference? If yes, who?*
Session Availability: M T W TH F	*This will be taken into account but does not guarantee sessions with that counselor. Referral: ___ Church/Pastor ___ Returning Client ___ Freedom ___ Family/Friend ___ Website ___ Clinical Referral Have you been here before for counseling? <input type="checkbox"/> Yes <input type="checkbox"/> No
Please list any medications you are currently taking.	Comments:

For Office Use Only Initial Client call: _____ Date Contacted _____ Assigned Counselor: _____
Cindy Phillips <input type="checkbox"/> Ramsey Miller <input type="checkbox"/> Jennifer Bowers <input type="checkbox"/> Jenifer Suri <input type="checkbox"/>

Intake Coordinator's Initials _____ Date. _____