Michael Dawson, MA, LPC
Christian and Traditional Counseling

Fully Living

Confidential Counseling Intake

Name: _____ Date: _____

Home Address: _____ DOB: _____/ _____/ _____ Age: _____

City, State, Zip: _____ SS#: _____ - _____ - _____

Home Phone: (_____) _____ - _____ Sex: Male ❑ Female ❑

Cell Phone: (_____) _____ - _____ Email: _____

Ok to email newsletter? Y ❑ N ❑

Employer: _____ Work Phone: (_____) _____ -_____

Highest Level of Education: _____ Spouse's _____

May we reach you: Home: Yes ❑ No ❑ Work: Yes ❑ No ❑ Cell: Yes ❑ No ❑ Text: Yes ❑ No ❑

May we send mail to you at your home address? Yes ❑ No ❑

Marital Status: Never Married ❑ Married ❑ Widowed ❑ Separated ❑ Divorced ❑

If Currently Married, how long: _____

Spouse's Name: _____ Age: _____

Children's Names: _____ Age: _____

_____ Age: _____

_____ Age: _____

Please list any other persons living in the home: _____

Previous Marriage: Yes ❑ No ❑ Name of Previous Spouse: _____ Married How Long?_____

Health & Personal Information

Would you describe your current physical health as: Excellent ❑ Good ❑ Fair ❑ Poor ❑

Would you describe your current diet as: Excellent ❑ Good ❑ Fair ❑ Poor ❑

How many hours do you sleep each night?_____

Do you currently have any physical problems? Yes ❑ No ❑ If yes, please explain: _____

_____

Please list any medical conditions or any disabilities: _____

_____

www.fullylivingnow.com
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Have you or anyone in your family been diagnosed or treated for any mental illness? Yes ❑ No ❑ If yes, explain:

_____

Have you ever been in counseling before? Yes ❑ No ❑ If yes, please provide counselor name and location, dates,

and reason for counseling: _____

_____

Please list all prescription and OTC medications currently being taken:

Medication	Dosage	Physician	Purpose

Have you ever taken illegal drugs? Yes ❑ No ❑

Do you drink alcoholic beverages Yes ❑ No ❑ How many average per day? _____ per week?_____

Are religious or spiritual issues important to you? Yes ❑ No ❑

How much do they influence your daily life? A great deal ❑ A reasonable amount ❑ Some ❑ Very little ❑

Do you currently attend church? Yes ❑ No ❑

If yes, where do you attend? _____

How did you hear about Fully Living; Michael Dawson? _____

What concerns are you seeking counseling for today? _____

_____

How often are you troubled by these concerns? Constantly ❑ Often ❑ Sometimes ❑ Not very often ❑

Please indicate your current level of the following symptoms or behaviors:

	Never	**Rarely**	**Sometimes**	**Frequently**
Feeling angry or having outbursts:	❑	❑	❑	❑
Feeling distant from God:	❑	❑	❑	❑
Trouble controlling worry or anxiety:	❑	❑	❑	❑
Life is hopeless:	❑	❑	❑	❑
Withdrawing from relationships:	❑	❑	❑	❑
Excessive use of alcohol or drugs:	❑	❑	❑	❑
Loss of sexual interest:	❑	❑	❑	❑
Feelings of depression:	❑	❑	❑	❑
Nightmares:	❑	❑	❑	❑

	Never	Rarely	Sometimes	Frequently
Afraid of specific places or things:	❑	❑	❑	❑
Excessive recurring thoughts:	❑	❑	❑	❑
Having little self-confidence:	❑	❑	❑	❑
I do not deserve to be forgiven:	❑	❑	❑	❑
Obsession with certain activities:	❑	❑	❑	❑
Feeling of stress, under too much pressure:	❑	❑	❑	❑
Mood shifts:	❑	❑	❑	❑
I am often physically sick:	❑	❑	❑	❑

Have you ever been involved in any **Traumatic situations**? If yes, please explain: _____

_____

Family of Origin

Present During Childhood:

	Present Entire Childhood	Present Part of Childhood	Not Present at All
Mother	❑	❑	❑
Father	❑	❑	❑
Step Mother	❑	❑	❑
Step Father	❑	❑	❑
Brother(s)	❑	❑	❑
Sister(s)	❑	❑	❑
Other _____	❑	❑	❑

Describe Childhood Family Experience

❑ Outstanding Home Environment
❑ Normal Home Environment
❑ Chaotic Home Environment
❑ Witnessed Abuse toward others
❑ Experienced Abuse from others

Parents' Current Marital Status:

❑ Married to each other
❑ Separated for _____ years
❑ Divorced for _____ years
❑ Mother remarried _____ times
❑ Father remarried _____ times

❑ Mother involved with someone
❑ Father involved with someone
❑ Mother deceased for _____ years
Age of client at mother's death _____
❑ Father deceased for _____ years
Age of client at father's death _____

Emergency Contact

Who should we contact in case of an emergency?

Name: _____ Relationship:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address:_____ City, State, Zip: _____

Client Signature: _____