Rays of Hope

PO BOX 901214, KCMO 64190-1214, 816-536-0042

Intake Form

Today's date:	

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Home Phone	Cell Phone	**Do Not call me at** Home ☐ Work ☐ Cell ☐	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	e-mail:	Work Phone:

Driver's License:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Hours worked per week	Yrs at Job	Highest level of Education	
Do you regularly attend church, synagogue, or other religious institution?	Are you a member?		
Name of Church:	Name of Pastor		
Do you have any religious beliefs that would be helpful for me to know about?	If yes, explain:		
Physician Coordinating your Care:	Phone:	Fax:	
MD's Address:			
Date of last Appt:			
REFERRAL INFORMATION			
Referred by (please check one box):	❑ Dr. _____	❑ Hosp_____	

❑ Family	❑ Friend	❑ Pastor_____	❑ Other_____	
Other family members seen by Rays of Hope (ROH):				

RELATIONSHIP INFORMATION

If engaged, married, divorced, or widowed, how long have you been so?		Number of previous marriages for you:	Number of previous marriages for your spouse:
Name of spouse			
Spouse' s age		Spouse's occupation:	
How would you describe your spouse? (angry, supportive,stubborn)			

Please list your children, including step, adopted, and foster children

Name	Sex	Age/Year of Death	Relationship to You	Living with Whom	Brief Description

Family of Origin

Please List your mother, father, brothers, sister, stepfamily and/or relatives who had a significant influence in your life (positive and negative).

Name	Sex	Age/Year of Death	Relationship to You	Brief Description

COUNSELING HISTORY

Name of Therapist/Program	Any Contact Info	Issues Addressed	Dates Attended
Pain Specialists Seen	**Any Contact Info**	**Services Received**	**Dates Attended**

Has anyone in your family ever been treated or hospitalized for substance abuse, mental health issues, or psychiatric conditions? ☐ Yes ☐ No

If yes, please describe_____

Have any of your family or friends ever attempted or committed suicide? Yes ☐ no ☐

If yes, who and when?_____

SYMPTOM CHECKLIST

Are you currently experiencing any suicidal thoughts ?	**Yes or No**
Have you experienced suicidal thoughts or attempted suicide in the past?	**Yes or No**
Are you currently experiencing any violent or homicidal thoughts?	**Yes or No**

Please check any of the following symptoms or problems that you are currently or have recently experienced.

☐	Sadness	☐	Uncontrollable crying spells	☐	Irritable mood	☐	Insomnia
☐	Sleeping too much	☐	Weight loss	☐	Weight gain	☐	Feeling empty
☐	Depressed mood	☐	Fatigue	☐	Apathy	☐	Spiritual apathy
☐	Lack of motivation	☐	Feeling worthless	☐	Angry	☐	Irritable
☐	Mood swings	☐	Excessive energy	☐	More talkative than usual	☐	Rapid speech
☐	Racing thoughts	☐	Poor judgment	☐	Impulsivity	☐	Excessive spending
☐	Explosive temper	☐	Excessive worrying	☐	Panic	☐	Distressing memories
☐	Nightmares	☐	Obsessive thoughts	☐	Compulsive behaviors	☐	Feeling numb
☐	Unable to concentrate	☐	Easily startled	☐	Forgetful	☐	Restless
☐	Marital difficulties	☐	Intrusive thoughts	☐	Difficulty saying no	☐	Inpatient
☐	Loss of appetite	☐	Low self esteem	☐	Fear of rejection	☐	Uncomfortable in social settings
☐	Fear of failure	☐	Withdrawn	☐	Stress	☐	Loneliness
☐	Indecisiveness	☐	Relational issues	☐	Financial issues	☐	Grief
☐	Sexual abuse	☐	Sexual addiction	☐	Poor concentration	☐	Aggression
☐	Emotional abuse	☐	Controlling	☐	Hearing voices	☐	Physical abuse
☐	Loss of control	☐	Controlled by others	☐	Gender identity	☐	Pregnancy/abortion
☐	Career choices	☐	Visual hallucinations	☐	Anxiety	☐	Fears
☐	Work issues	☐	Loss	☐	Alcohol use	☐	Drug use
☐	Academic problems	☐	Guilt	☐	Dependence	☐	Mood swings
☐	Procrastination	☐	Hopelessness	☐	Perfectionism	☐	Distractibility

Please state in your own words why you are coming to Rays of Hope for counseling.

_____

_____

PAIN ASSESSMENT			
IF YOU HAVE PHYSICAL PAIN PLEASE COMPLETE (OTHERWISEYOU MAY SKIP AND SIGN BELOW)			
Location(s) of Pain:			

Description of pain (If I were feeling your pain, what would I be feeling)

Mark your Range of Pain Intensity (Lowest pain rating and Highest)

0 1 2 3 4 5 6 7 8 9 10

Mark your average level of Pain (circle only one number)

0 1 2 3 4 5 6 7 8 9 10

What Increases Your Pain?

What Decreases Your Pain?

Client Signature _____Date_____