



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:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Home Phone	Cell Phone	Do Not call me at Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/>			Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> 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):			<input type="checkbox"/> Dr. _____	<input type="checkbox"/> Hosp _____
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Pastor _____	<input type="checkbox"/> 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? _____

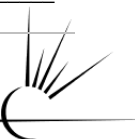
SYMPTOM CHECKLIST

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 (OTHERWISE YOU MAY SKIP AND SIGN BELOW)

Location(s) of Pain:			
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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 _____

