Intake for Pastoral Counseling

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I understand that Scott Fleming is a Board Certified Clinical Chaplain and Pastoral Counselor with the College of Pastoral Supervision and Psychotherapy. He received his theological education from The Baptist College of Florida and New Orleans Baptist Theological Seminary, and has more than 2,400 hours of clinical training. He is ordained endorsed / commissioned by his denomination as a Chaplain and Pastoral Counselor. I understand that this is an extension of his pastoral ministry and that he is not licensed as a mental health professional in the State of Florida.

I have been informed that Pastoral Counseling is a ministry that is a hybrid of spirituality, psychology, religious beliefs (scripture), and personal self-introspection of the heart.

I recognize that this step of faith has been helpful for many but may need to be referred to a professional mental health counselor or psychologist. I understand that I might experience heightened emotions and memories that were previously unknown or unresolved, that neither I nor anyone else knew about in advance. I will not hold any of the participants responsible for my memories or behaviors.

I understand that sessions will be one hour long each time, and that the pastoral counselor may terminate this agreement in the event that he believes a referral is appropriate.

I give my consent for pastoral counseling, and am in no way being forced, pressured, or coerced to submit to this procedure from any person or entity. I also have the right to terminate the session at any time without penalty.

I understand that I am not obligated to fill out any items on this form that I am uncomfortable with answering, except for those relating to medical or psychological history.

My signature is an acknowledgement that I have been informed of my rights and have had the opportunity to obtain whatever information or professional advice I deemed necessary or appropriate prior to undergoing deliverance.

Printed Name Date

Client’s Signature

**Counseling Intake Form**

Please complete and print this form for your next session. This will reduce the amount of time your session will have to spend to ascertain specific information. This information is confidential and will not be released to anyone without your permission. Thank You.

Today’s Date:

Basic Information

Client’s Full Name

Address

City, State, Zip Code

Home Phone - - Cell Phone - - Home Phone - -

Best Phone to reach you - - Can we text you? Yes No Date of Birth Age Sex (M/F)

Emergency Contact Name Phone#

Responsible Party (applicable only to minors or if different from client)

Relationship of client to responsible party

Name

Address

City, State, Zip Code

Home Phone - - Cell Phone - - Home Phone - -

Marital Status

Single

Married for years

Divorced for years after a marriage of years.

Separated for years after a marriage of years.

Widowed for years after a marriage of years.

How many times have you been married?

How happy is your current marriage?

Are your parents presently married or divorced? If divorced what was your age at the time of the divorce?

Was there a sense of security and harmony in your home the first 12 years of your life. If no, please describe.

Was your father clearly the head of the home, or was there a role reversal in which your mother ruled the home? Please describe.

To your knowledge, were any of your parents or grandparents ever involved in an adulterous affair? Please describe.

Where your parents strict or permissive?

If your parents are deceased, what year? Your age at the time?

Cause of death

If you were raised by someone other than your birth parents, please describe the situation in some detail.

Education and Occupation

Education status: Currently a student? Yes No School:

Highest degree or year of schooling obtained and major

Current Occupation

Are you happy with your work? Yes No Medical, Physical and Counseling History

Have you ever consulted a therapist before? Yes No

If so, when?

For what period of time?

What was the major problem discussed?

Are there any medical problems we should be aware of?

Do you think now or in the past you have had an addiction to something? Yes No

If yes, what?

Have you ever seriously considered or attempted suicide? Yes No If so, when

Have you been, or are you now, taking any medications for either physical or psychological reasons? Yes No

If yes, what medications and for what problems? Please list medications and dosages, if you know them.

Have you ever been hospitalized for a physical illness? Yes No

If yes, please explain

Have you ever been hospitalized for a mental illness? Yes No

If yes, please explain

Do you have problems sleeping? Are you having reoccurring nightmares or disturbances?

Yes No

If yes, please describe

Have you ever been beaten or sexually molested? Yes No

If yes, please describe

Are there any addictive problems in your family (alcohol, drugs, sex etc.)? Yes No

If yes, please describe

Is there any history of mental illness? Yes No

If yes, please describe

Do you have any recurrent or chronic conditions? Yes No

If yes, please describe

Do you smoke? Yes No If yes, how many per day?

Do you take drugs? Yes No If yes, what kind and how often?

Do you drink alcohol? Yes No If yes, how often?

Which of the following have you struggled with in the past or are your struggling with presently?

daydreaming

lustful thoughts

thoughts of inferiority

thoughts or inadequacy

worry

doubts

fantasy

obsessive thoughts

insecurity

blasphemous thoughts compulsive thoughts

dizziness

headaches

hear voices

see images that are not there

Emotional:

Which of the following emotions do you struggle with:

frustration

anger

anxiety

depression

bitterness

hatred

worthlessness

Do you believe any of the above emotions are sinful? If yes, why?

Our Present Priorities

The checklist below may help you recognize those areas of priorities in our lives. Please check the ones that apply to your life at present.

Ambition Food or any substance Money/ possessions

Computer/games/software Financial security Rock stars/media celebrities/athletes

Church activities

TV/movies/music/other media

Sports or physical fitness Fun/pleasure

Ministry Appearance /image

Work

Busyness/activity Friends

Popularity/ opinio of others

Spouse Boyfriend/Girlfriend

Knowledge/being right

Children Hobbies

Parents

Power/control

Fear Checklist

Check the fears that apply to your life. Write down others that come to mind.

fear of death

fear rejection by people

fear of failure

fear of disapproval

fear of becoming homosexual/being homosexual

fear of Satan

fear of financial problems fear of never getting married

fear of death of a loved one

fear of being a hopeless case

fear of marriage

fear of the death of a loved one fear of not being loved by God

fear of never loving or being loved by others

fear of being victimized by crime

fear of divorce

fear of going crazy

fear of pain/illness

fear of the future

fear of confrontation fear of specific individuals (Please list)

Other specific Fears that come to mind now Please list

Other

What do you see as the chief problem you need to resolve with a counselor?

Why are you coming to see us now?

What do you wish to achieve in our session?

Do you have any concerns or worries about pastoral counseling?

Have you been previously diagnosed by a professional counselor? Yes No