55 Adclare Road
Rockville, MD 20850
301-279-2400 • Fax: 301-340-1121

Office Use Only – Counselors please complete before submitting new Intakes.

Initial Interview Date

Location ______________________ **Counselor** ______________________

INTAKE FORM

Please print and give complete information

Counselee Name______________________________ Male/Female______ Race________________
Date of Birth_______________________ Current Age______Social Security Number______________
Parent(s)/Guardian (if under 18 years of age)____
Street Address____
City______________________________State______ Zip Code______________________________
County of Residence___________________________
Telephone____________Work Telephone_____________Other (specify)___________________
May a telephone message be left for you at these numbers? ☐ Yes ☐ No

Please indicate any restrictions for leaving messages____

Current Marital Status:
☐ Single ☐ Engaged ☐ Married ☐ Remarried ☐ Separated ☐ Divorced ☐ Widowed ☐ Living w/Significant Other

Spouse's Name: ____

Would you like to receive church newsletters via email? __No __Yes, Email Address: ___________________

People Living in the Home - Male	Age	People Living in the Home - Female	Age

Spiritual: Religious Denomination/Affiliation___________________ Church Attending ______________________

Referral: How did you learn about First Baptist Rockville?__ Clergy __Family __Friend __Website/Online Search
__ Physician __Other (BCMD/Church/FBCR Counselor/Phonebook) ______________________________
Name of referring person/agency/church ____

Education: (circle highest grade completed) 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 20+
Degree/Major __________________________ School (if currently a student) __________________________

(Note: if client is a minor, please complete the following employment information for parents'/guardians' employment)

Employer/Company _______________________ Job Title__________________ Gross Salary __________
Street Address____ State _____ Zip Code ________________
Spouse's Employer _______________________ Job Title________________ Gross Salary _______________
Street Address ____________________ City _______________ State _______ Zip Code __________________

Medical and Mental Health Information

Primary Physician____Telephone____________________________________
Street Address ____ City __________State ______ Zip Code ___________

Please list any current medical conditions and treatments (including prescription, over-the counter, herbal, etc.)

Medical Condition/Concern	Medication/Treatment	Dosage/Frequency

Are you currently seeing a psychiatrist, psychologist, or other counselor/therapist? ___Yes ___No

Name ____Telephone____________________________________
Street Address ____ City __________State ______ Zip Code__________
Have you ever received psychological services before? ___Yes ___No

When? From/To	Clinician/Therapist/Agency	Reason for Treatment	Results

Have you ever taken medications for emotional or psychological problems? ___Yes ___No

When?	Prescribing Physician	What Medication?	For What?	Results

Please indicate the frequency and amount that you currently consume: (quantity, time, cups, etc.)

	How much?	How often?			
Caffeine			Recent Increase	Recent Decrease	Past Use
Alcohol			Recent Increase	Recent Decrease	Past Use
Tobacco			Recent Increase	Recent Decrease	Past Use
Marijuana			Recent Increase	Recent Decrease	Past Use
Pornography			Recent Increase	Recent Decrease	Past Use

What is happening in your life that resulted in this appointment? Briefly summarize issues you wish to discuss.

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FIRST BAPTIST rockville