BIG FISH
MINISTRIES

CLIENT INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer, or would prefer to discuss with your therapist. Information you provide here is held to the same standards of confidentiality as our therapy.

CONTACT INFORMATION

Name: _____ Birthdate: _____

Address: _____

Phone Number: _____

Email: _____

Best way to reach you: _____

TREATMENT HISTORY

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ( ) yes ( ) no

Have you had previous mental health treatment?
( ) no
( ) yes, with (previous therapist's name)_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)? ( ) yes ( ) no

If yes, please list: _____

Prescribed by: _____

HEALTH AND SOCIAL INFORMATION

Do you currently have a primary physician? ( ) yes ( ) no

If yes, who is it? _____

Do you regularly use alcohol? ( ) no ( ) yes
In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

Office: 251.943.6990
South Store: 251.970.0031
North Store: 251.943.9513

Office: P.O. Box 895, Foley, AL 36536
South Store: 8475 Hwy 59 S
North Store: 802 McZenzie St

contact@bigfishministries.org
www.bigfishministries.org

How often do you engage recreational drug use?
( ) daily ( ) weekly ( ) monthly ( ) rarely ( ) never

What recreational drugs do you use:

_____

Do you smoke cigarettes or use other tobacco products?
( ) yes ( ) no

Have you had suicidal thoughts recently?
( ) frequently ( ) sometimes ( ) rarely ( ) never

Have you had them in the past?
( ) frequently ( ) sometimes ( ) rarely ( ) never

In the last year, have you experienced any significant life changes or stressors? If yes, please explain:

_____

_____

OCCUPATIONAL INFORMATION

Are you currently employed? ( ) no ( ) yes

If yes, who is your currently employer/position? _____

If yes, are you happy with your current position? _____

Please list any work-related stressors, if any: _____

_____

_____

RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious? ( ) no ( ) yes

If yes, what is your faith? _____

If you attend church regularly, please list church of attendance:

_____

OTHER INFORMATION

What do you consider to be your strengths? _____

_____

_____

What do you like most about yourself? _____

_____

What are most helpful coping strategies that you have used? _____

_____

_____

What are your top 3 goals for outpatient treatment?

_____

_____

_____

The Outpatient Program is an 8-week program including 1 hr. of individual counseling with the Outpatient Director and 1 hr. of group meetings with peers.

I _____ agree to pay for this 8-week program.
(signature)

Any unexcused absences or drug/alcohol use during the program may cause dismissal from the program.

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPPA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/ authorized representative to who it pertains unless other permitted by law.