



# Rodgers Christian Counseling



## RCCA Couples Intake Form

RCCA Therapist Name \_\_\_\_\_

Client's Names \_\_\_\_\_ Today's Date \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

How did you find out about RCCA? (Referral Source)

\_\_\_\_\_

***His Information:***

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Work \_\_\_\_\_ Which of these is the best way to reach you? \_\_\_\_\_

Email Address (s): \_\_\_\_\_

\_\_\_\_\_

May we send you emails Y/N Mail Y/N for upcoming workshops, groups, classes and webinars?

Date of Birth: \_\_\_\_\_ Married? \_\_\_\_\_ Anniversary: \_\_\_\_\_

Previous marriages? \_\_\_\_\_ How Many? \_\_\_\_\_ How long were their duration? \_\_\_\_\_

Do you have any siblings? \_\_\_\_\_ If so, how many? \_\_\_\_\_ Where are you in the birth order? \_\_\_\_\_

Is your family part of your support system? \_\_\_\_\_ Do they live in the local area? \_\_\_\_\_

Please give the following information for each person that currently lives in your home, ***including yourself***

Name	Age	Relationship to Self
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

\_\_\_\_\_

Please also list any other people in your immediate family who may not be living in your house:

Name	Age	Relationship to Self
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Personal and Medical Information:**

Are you currently taking any prescription medications? \_\_\_\_\_ Name of Medication \_\_\_\_\_

List any past or present medical issues: \_\_\_\_\_

List any secondary issues, (sleeplessness, panic attacks, phobias) : \_\_\_\_\_

Note any significant events occurring at this time (job loss, death in family, financial trouble): \_\_\_\_\_

List any emotional issues that are present (anger, anxiety, moodiness) : \_\_\_\_\_

Have you had thoughts of harming yourself or ending your life ? \_\_\_\_\_

**Family History (please include yourself in this and specify whom it is in your family):**

Alcoholism/Drug Abuse: \_\_\_\_\_

Depression, Manic/Depression, Schizophrenia: \_\_\_\_\_

Other mental illness: \_\_\_\_\_

Emotional, verbal, physical, sexual abuse: \_\_\_\_\_

Other significant childhood traumas: \_\_\_\_\_

**Back Ground Information:**

Do you currently attend church? \_\_\_\_\_ What is your role in church? \_\_\_\_\_

Which church do you attend? \_\_\_\_\_

Occupation? \_\_\_\_\_

Have you ever seen a therapist before? \_\_\_\_\_

Was it helpful and how? \_\_\_\_\_

What brings you here today? \_\_\_\_\_

***Her Information:***

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

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_____	_____	_____
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