STATEMENT OF PURPOSE & PRACTICE

The Care & Counseling Center of First Baptist Concord exists to meet care and counseling needs with Biblical answers. Our care may include meeting with our in-house pastors and counselors, our church support ministries or referrals to area or regional specialized counselors or ministries. Frequent attenders of First Baptist Concord are not charged to visit with First Baptist Concord pastors or counselors.

I understand that if I have come with my spouse for marriage counseling, and we see different counselors, the counselors have the liberty to discuss our marriage with each other for the purpose of developing a plan of care.

First Baptist Concord practices Biblical Counseling, believing the solutions to man's problems lie in a personal relationship with Jesus Christ and the life-change that comes by the Holy Spirit – who is Comforter and Counselor—through adherence to the Word of God. Our approach values and often refers to the knowledge gained in the fields of psychology and medicine, recognizing that medical attention may be needed.

My signature indicates I understand and accept the above statement.

_____ ____/_____/_____

Signature Date

The Care & Counseling Center of First Baptist Concord does not offer 24-hour counseling availability. If you think you are a danger to yourself or others, call 911 or the Mobile Crisis Unit at 865.539.2409.

Name_____DOB ____/____/____

Address_____

_____

Home Phone _____/_____/_____ Cell Phone_____/_____/_____ Email_____

Are you a FB Concord Member? _____

If no, do you frequently attend worship services? _____

Family Status: ___Married ___Single __Divorced ___Widow/Widower

Names & Ages of Children_____

_____

Please write a thorough explanation of your need below or by email to vlee@fbconcord.org.

COUNSELING INTAKE FORM

Date: _____

Client's Name _____ Date of Birth: _____ Social Security _____

Marital Status: Single ___ Engaged ___ Married ___ Divorced ___ Widowed ___ Separated ___ Date: _____

Race: _____ Ethnicity: _____ Nationality: _____

Parent / Guardian's Name (*minor clients*) _____ Partner's Name: _____

Additional Family Members & Ages: _____

_____

Home Address: _____ City _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Fax Number _____ Leave Message at Home? Yes __ No __ Leave Message at Work? Yes __ No __

E-mail Address _____ Web-page or My Space _____

Employer's Name _____ Address _____

Job Title _____ Length of time employed by this employer _____

Referred by: _____ Phone: _____

Religious Background: _____

Church: _____ Address: _____

Pastor: _____ Phone: _____

Physician: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Medical Conditions: _____

Allergies: _____

Highest Level of Education: _____ Major _____

Schools graduated from _____

Medication Currently Taken (include vitamins, minerals and other nutritional supplements): _____

_____

Current Weight: _____ Height: _____ Eyes: _____ Hair: _____

Previous Therapy? Yes ___ No ___ Former Therapist: _____

Describe the benefit of your previous therapy _____

_____

Medical History:

Hospitalizations:

Military History:

PERSONAL HISTORY / PROBLEM EVALUATION
BASIC PROBLEM IDENTIFICATION

Please check any of the follow symptoms or conditions you have had or are now experiencing.

CONDITION:	PAST More than 6 months	PRESENT Less than 6 months
Mood high & lows	____	____
Weight loss or gain	____	____
Appetite changes	____	____
Drug usage (*description* _____) (*amount per week* _____)	____	____
Cigarette smoking	____	____
Tobacco usage	____	____
Irritability	____	____
Excessive stress	____	____
Crying spells	____	____
Phobias or fears	____	____
Hallucinations	____	____
Confusion	____	____
Low self-esteem	____	____
Compulsive behaviors	____	____
Depression	____	____
Extreme nervousness	____	____
Lack of Motivation	____	____
Alcohol Consumption (*description* _____) (*amount per week* _____)	____	____
Indecisiveness	____	____
Loss of memory	____	____
Fantasizing	____	____

CONDITION:	PAST More than 6 months	PRESENT Less than 6 months
Physical abuse from others	____	____
Sexual abuse from others	____	____
Insomnia (can't sleep)	____	____
Excessive worries	____	____
Difficulty concentrating	____	____
Hearing unseen voices	____	____
Frequent loss of temper	____	____
Acting out violence	____	____
Frequent residence changes	____	____
Frequent employment changes	____	____
Bed wetting past age 6	____	____
Fire setting past age 6	____	____
Blaming others frequently	____	____
Lack of sexual desire	____	____
Spiritual confusion	____	____
Thoughts of suicide	____	____
Difficulty reading	____	____
Inability to comprehend math	____	____
Inability to express yourself	____	____
Involvement with the occult	____	____
Use of pornography	____	____
Physical abuse of children	____	____
Sexual abuse of children	____	____
Physical abuse of others	____	____
Excessive sexual activity	____	____

1. When (approximately) did you have a complete physical examination? _____ Where? _____

2. What physical disorders do you have, if any? _____
   _____
   _____

3. Describe your current relationship to God. _____
   _____
   _____
   _____
   _____
   _____
   _____