Bayside Counseling Center
8303 Sierra College Blvd. St. 150
Roseville, California 95661
Phone: (916) 746-7228
www.counselor@baysideonline.com

NEW CLIENT INTAKE FORM - ADULT, COUPLE, FAMILY

Welcome to BCC, the professional counseling ministry at Bayside Church. We look forward to walking with you as you embark on this courageous journey of counselling.

Today's Date: _____

Directions

Please complete this New Client Intake Form for each counseling participant. For example, one form for an individual and two forms for each participant of a couple. Please note that if the counseling participant is a minor receiving services, at least one parent must accompany the child to sign forms. We strongly encourage each client to take the time to thoroughly complete this form. We have found that doing so will greatly enrich the start of your experience, assisting your counselor in tailoring the best treatment possible for you.

Once complete, please submit the form(s) in one of the following three ways:

1) Scan/Email the form(s) to our Counseling Administrator at: counselor@baysideonline.com
2) Drop the completed form(s) off, in a sealed envelope, in the confidential lockbox located in the Counseling waiting room on Monday through Friday from 9:00am to 4:00pm.
3) Mail the form in a sealed envelope, using this address: 8205 Sierra College Blvd. Roseville, CA 95661

All the above options are confidentially monitored by BCC staff, Monday through Friday. Once received, you will be contacted within two business days, via email, with confirmation and an update on the current referral-to-counselor process along with additional paperwork to bring to your first appointment.

General Information

_____ _____ _____
Client Name Date of Birth Age

_____ _____
Name of Person filling out form (if different) Relationship to Client

_____
Client Address

_____ _____ _____
Cell Phone Other Phone Email Address (*Required)

_____ _____ _____
Spouse's Name (if applicable) Contact Phone Age

_____
Children (Names/Ages)

_____ _____
Emergency Contact Name (if not significant other) Emergency Contact Phone

Highest Education 9th ☐ 10th ☐ 11th ☐ 12th ☐ Some college ☐ Graduated college ☐ Post-graduate ☐

_____ _____
Occupation Spouse's Occupation (if applicable)

Counseling Information

How did you hear about BCC? _____

Have you been seen by a BCC counselor before? Yes ☐ No ☐ Approx. Dates:_____

Have you had previous counseling or psychotherapy outside of BCC? Yes ☐ No ☐ Approx. Dates:_____

What were the reasons for previously seeking counseling/psychotherapy?_____

Did you have a positive experience either within or outside BCC? Yes ☐ No ☐ I Don't Know ☐

Please briefly describe what brings you to therapy:_____

_____

Please describe what you hope to achieve in therapy:_____

Services desired: Individual therapy ☐ Marital/Couples therapy ☐ Family therapy ☐ Pre-marital therapy ☐

How do you prefer to be contacted? Please check all that apply. Phone Call ☐ Text* ☐ Email* ☐

Some counselors are willing to maintain contact with you via text, email, or other electronic means for the purpose of scheduling or rescheduling only. Although we cannot be certain that this information will not be intercepted, we will do our part to protect your confidentiality.

_____ Please initial here indicating you understand the risks of communicating by electronic means, still wish to do so, and consent to electronic communication with BCC at Bayside Church.

When we contact you, may we identify ourselves as counselors from BCC or Bayside Church? Yes ☐ No ☐

Please provide at least two days and ranges of times. We will make every effort to meet your availability, however, this is not a guarantee for appointment days and/or times. Also note that the counselors often call clients using a blocked, confidential phone number. Be aware that your therapist may be making multiple attempts to reach you.

Days:	Mondays	Tuesdays	Wednesdays	Thursdays	Fridays	Saturdays	Sundays
Times:							

Financial Information

Bayside strives to offer quality counseling at an affordable price**, The cost for a 50-minute session with an Associate Therapists is $100. The fee for a fully Licensed Therapist is set by the individual clinician starting at $125+.** Should you require financial assistance please download our client assistance application or contact our office. That decision will be determined by monthly gross household income and ability to pay. To access the center's sliding scale or to see a Trainee at a reduced rate financial documentation is required. (*Trainees are current graduate students studying toward their degree, while Associate therapists have obtained their degree and working towards their 3000 hrs. required for full licensure)

Please check all that apply:

☐ I will be participating in individual, couple's, child or family counseling

My monthly gross household income is: _____

☐ I am a Bayside staff member or an immediate family member of the staff. Staff Name: _____

Personal History Inventory

Thank you in advance for openly providing the details below. All information will remain confidential as stated in the Informed Consent Form provided to you by BCC prior to the start of therapy. This assessment provides your counselor with additional information to clinically support you. Please check all that apply.

Marital Status:
- ☐ Single, never married
- ☐ Live-in partner (for___ years)
- ☐ Engaged (for ___ months)
- ☐ Married (for ___ years)
- ☐ Widowed (for ___ years)
- ☐ Separated (for ___ years
- ☐ Divorced (for ___ years)
- ☐ Prior marriages (number ___)

Employment:
- ☐ Unemployed
- ☐ Student, part time
- ☐ Student, full time
- ☐ Employed, satisfied
- ☐ Employed, dissatisfied
- ☐ Coworker conflicts
- ☐ Supervisor conflicts
- ☐ Other: _____

Social Support System:
- ☐ Supportive network
- ☐ Involved in church/community
- ☐ Few friends
- ☐ Distant from family
- ☐ No friends
- ☐ Other:_____

Financial Situation:
- ☐ No current financial problems
- ☐ Poverty or below-poverty income
- ☐ Large indebtedness
- ☐ Impulsive spending
- ☐ Relationship conflicts over finances
- ☐ Other: _____

Military History:
- ☐ Never personally in military
- ☐ Military family growing up
- ☐ Currently in military
- ☐ Served in military – honorably discharged
- ☐ Served in military – dishonorably discharged
- ☐ Served in military – retired
- ☐ Other: _____

Legal History:
- ☐ No legal issues
- ☐ Past/Current parole/probation
- ☐ Arrest(s) – Not substance-related
- ☐ Arrest(s) – Substance-related
- ☐ Therapy/Counseling is court-ordered
- ☐ Past Jail/Prison time (___ # of times)
- ☐ Other: _____

Substance Use History:
- ☐ No current use
- ☐ Active use: _____
  (Frequency: Daily ☐ Weekly ☐ Monthly ☐)
- ☐ No history of abuse
- ☐ Active abuse: _____
- ☐ Past abuse: _____

Current Use of Substance(s):
- ☐ Caffeine
- ☐ Alcohol
- ☐ Nicotine
- ☐ Prescription meds
- ☐ Marijuana
- ☐ Other: screen addiction, shopping, gambling, etc

Treatment History:
- ☐ No treatment history
- ☐ Outpatient (Last Date: _____)
- ☐ Inpatient (Last Date: _____)
- ☐ 12-Step Program (Last Date: _____)
- ☐ Stopped independently (Date: _____)
- ☐ Other: _____

Family Substance Abuse History:
- ☐ Parent(s)/Guardian(s)
- ☐ Grandparent(s)
- ☐ Sibling(s)
- ☐ Uncle(s)/Aunt(s)
- ☐ Spouse/Significant Other
- ☐ Children
- ☐ Other: _____

Current Household Members:

Please list household members other than yourself and spouse and state what your relation is to the other members. (i.e. biological child, adopted child, foster child, step-child, spouse's child, brother, sister, parent, friend, etc.)

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Spiritual Information:

How would you describe your faith/religious upbringing? _____

_____

Do you presently identify with a certain affiliation/denomination? Yes ☐ No ☐ I don't know ☐

If so, which one: _____

Do you currently attend a church? Yes ☐ No ☐ Sometimes ☐ If so, where:_____

Medical/Psychiatric History

Name of Doctor or
Psychiatrist:_____Phone:_____

Are you presently being treated for any health problems? Yes ☐ No ☐ If yes, please share the health problem(s)
_____

Date of last complete physical exam: _____

Please list all current medications, including dosage, frequency, and reason: _____

_____

Previous psychiatric, emotional, or substance use hospitalization and/or inpatient treatment? This includes any suicide attempts. Yes ☐ No ☐

If yes, please indicate the most recent date, reason, location, and number of occasions. _____

Family of Origin Information:

Place of Birth: _____ Ethnicity: _____
Did you move around a lot before the age of 18? Yes ☐ No ☐

Childhood Family Experience:

- ☐ Stable home environment
- ☐ Chaotic home environment
- ☐ Witnessed physical/verbal/sexual abuse toward others
- ☐ Experienced physical/verbal/sexual abuse from other

If raised by someone other than biological parents, who?_____

Any other details of your childhood and/or family of origin that you believe are important to know at the start of therapy?

_____

Target Symptoms
Please indicate all symptoms that you currently experience by marking the level that best describes their severity. Check on level for each applicable symptom and indicate how long the symptom has been present.

Depressed Mood	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Fatigue/Low Energy	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Hopelessness/Helplessness	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Elevated Mood	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Body Complaints	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Suicidal Ideas	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Weight Gain/Loss	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Anxiety	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Lack of Concentration	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Sleep Disturbance	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Panic	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Phobias	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Obsessions/Compulsions	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Impulse Control Issue (Temper)	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Violence, Anti-social Behavior	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Unusual Energy	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Racing Thoughts	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Disorganized Thinking	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Bizarre Ideation/Impulses	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Homicidal Impulses	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Binging/Purging	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Mood Swings	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Irritability	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Delusions	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Hallucinations	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Conduct Problems	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Social Isolation	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Worthlessness	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Hyperactivity	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Dissociative States	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Aggressive Behavior	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Alcohol/Substance Over Use	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Unwanted Habits/Coping Mechanisms (Screen use/ Gambling /Workaholism /Pornography, etc.)	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:

Thank you for being open about these details. All information will remain confidential.
Please follow the directions on Page 1 for submitting this form. As soon as it is received, we will be in contact within two business days, via email, with confirmation and a quick update on the current referral-to-counselor process.