



Bayside Counseling Center (BCC)

Bayside Counseling Center (BCC)
8303 Sierra College Blvd. St. 150
Roseville, California 95661
(Office location, not for mail purposes)
Phone: (916) 746-7228

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: www.care@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

BCC strives to offer quality counseling at an affordable price. **The fee for a session (50 minutes) is \$80.** Should you require financial assistance and wonder if you qualify for a sliding scale, that will be determined by monthly gross household income and ability to pay. Monthly gross income includes all forms of household income such as pension, disability, unemployment, stipends, commissions, salary, etc.

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 requesting an additional unit of treatment (e.g. individual & couples counseling, concurrently)

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

I will be participating in a counseling group. Name of Group _____

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: _____

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 <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Fatigue/Low Energy	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Hopelessness/Helplessness	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Elevated Mood	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Body Complaints	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Suicidal Ideas	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Weight Gain/Loss	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Anxiety	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Lack of Concentration	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Sleep Disturbance	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Panic	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Phobias	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Obsessions/Compulsions	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Impulse Control Issue (Temper)	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Violence, Anti-social Behavior	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Unusual Energy	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Racing Thoughts	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Disorganized Thinking	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Bizarre Ideation/Impulses	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Homicidal Impulses	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Binging/Purging	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Mood Swings	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Irritability	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Delusions	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Hallucinations	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Conduct Problems	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Social Isolation	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Worthlessness	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Hyperactivity	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Dissociative States	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Aggressive Behavior	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	Duration:
Alcohol/Substance Over Use	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	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. Again, welcome to BCC. We look forward to working with you.