



theriver@fvcf.co.za

041 367 1100 | 083 291 4171

## CONFIDENTIAL INTAKE FORM

Welcome to The River Community Life Centre. Please complete the following confidential questionnaire. The information you provide will be helpful to create the best fit with one of our counsellors. Please feel free to ask any questions.

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Email: \_\_\_\_\_ Home Language: \_\_\_\_\_

Cell Number: \_\_\_\_\_ Alternate Number: \_\_\_\_\_ Occupation: \_\_\_\_\_

Gender: \_\_\_\_\_

Religious background/involvement: \_\_\_\_\_

Emergency contact person:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Number: \_\_\_\_\_

Please describe your current living arrangements: (where and with whom) \_\_\_\_\_

\_\_\_\_\_

Have you previously participated in therapy? Yes  No  If yes, when and with whom

(pastor/counsellor/psychologist/psychiatrist)? \_\_\_\_\_

Reason: \_\_\_\_\_

Are you currently seeing a psychiatrist, therapist or helper? Yes  No

If yes, name of therapist: \_\_\_\_\_

Doctor's name and contact number: \_\_\_\_\_

Are you on any medications? Yes  No

If so, what medication and why? \_\_\_\_\_

How Can We Help? Please give a brief explanation of your need

---

---

---

What are your most important goals for therapy (what do you hope to get out of your time with a counsellor?)

---

---

Please check all symptoms/common problems that apply:

<input type="checkbox"/>	Marriage	<input type="checkbox"/>	Work/career	<input type="checkbox"/>	Grief/loss
<input type="checkbox"/>	Divorce/separation	<input type="checkbox"/>	School	<input type="checkbox"/>	Depression
<input type="checkbox"/>	Pre-marital	<input type="checkbox"/>	Finances	<input type="checkbox"/>	Fear/anxiety
<input type="checkbox"/>	Sexual issues	<input type="checkbox"/>	Self-esteem	<input type="checkbox"/>	Anger
<input type="checkbox"/>	Family	<input type="checkbox"/>	Body issues	<input type="checkbox"/>	Loneliness
<input type="checkbox"/>	Parenting	<input type="checkbox"/>	Eating disorder	<input type="checkbox"/>	Mood swings
<input type="checkbox"/>	In-laws	<input type="checkbox"/>	Drugs/alcohol	<input type="checkbox"/>	God/faith
<input type="checkbox"/>	Co-dependency	<input type="checkbox"/>	Other addictions	<input type="checkbox"/>	Church/ministry
<input type="checkbox"/>	Stress	<input type="checkbox"/>	Intimacy	<input type="checkbox"/>	Communication

**Family Information:**

Marital Status: Single  Dating  Committed relationship  Engaged

Married  (how long?) \_\_\_\_\_ Separated  (how long?) \_\_\_\_\_ Divorced  (how long?) \_\_\_\_\_

Relationship with friends: close  somewhat close  distant  conflicted

Relationship with mother: close  somewhat close  distant  conflicted

Relationship with father: close  somewhat close  distant  conflicted

**Crisis information:**

Are you currently experiencing suicidal thoughts, feelings or actions? Yes  No

If yes, please provide some more details about those thoughts, feelings or actions

---

Are currently experiencing violent thoughts, feelings or anger control problems? Yes  No

If yes, please provide some more details about those thoughts, feelings or anger control problems

---

Any current threats of significant loss or harm (illness, divorce, job loss, etc.)? Yes  No

If yes, please provide some more details \_\_\_\_\_

---

Thank you for completing the intake form. A counsellor will contact you and this will be reviewed with you during your first counselling session.