DayStar Ministries
900 SW Riverview Way
Troutdale, OR 97060, 503.481.2934
dsministries.com

CLIENT INTAKE FORM

Counselor's Name: _Daniel Sirstad, MA, LCPC_________ Date _____ / _____ / _____

Client's Name ____________________________________ DOB _____ / _____ / _____

Parent/guardian name (minor clients) ___________________________________

Marital status: ____single ____married ____divorced ____widowed ____separated

Home address: ________________________ City _________________ State _____ Zip _______

Home phone number ___________________ Work phone number _________________________

Leave message at home ___Y ___N Leave message at work ___Y___N

Cell phone number _____________________ Whose cell? _______________________________

Employer's name ______________________ Address ___________________________________

Referred by: __________________________ Physician _________________________________

Phone # ___________________________________

Client social security number _____ - _____ - _______

Medical conditions: ____

____

Past medications and dosage: ____

Current medication and dosage: ____

Allergies: ____

Previous Therapy _____Y _____N Former Therapist ___________________________

Was your previous therapy helpful _____Y _____N

What problems are you seeking counseling for now? ______________________________________

____

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Person who is financially responsible for today's visit ______________________________________

Billing address if different from client ____

Billing Phone Number :_________________________________

Today's visit will be paid by ____Cash _____Check _____CC

The counselor may discuss my case with the following people: ___________________________

____

Client's Signature ____ **Date** ______/_____/_____

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CONSENT TO TREATMENT AND CONFIDENTIALITY

I, ____________________________, request counseling services from:

DayStar Ministries
900 SW Riverview Way
Troutdale, OR 97060

I hereby authorize the counseling staff of the above stated facility to provide consultation and referral services. I have been informed of the nature and purpose of this service and that my consent can be revoked orally or in writing prior to, and or, during the consultation period. I have read and fully understand the above authorization of counseling/consultation. No guarantee or assurance has been made to me as to any of the results that may be obtained from these services. I hereby release from any and all liability the staff, counselors, and employees of the above mentioned center from any and all decisions and actions that I may or may not take as a result of the counseling I receive at this center. I understand that Christian Counseling is spiritual, not medical, in nature.

Check One: I request Christian counseling _____ I don't request Christian counseling _____

Client's Signature ____ **Date** ______/_____/_____

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Please check any of the following symptoms or conditions you have had or are now experiencing:

CONDITION	**Past**	**Present**	**CONDITION**	**Past**	**Present**
Mood highs and lows			Insomnia (can't sleep)		
Weight loss or gain			Excessive worries		
Appetite changes			Difficulty concentrating		
Drug usage			Hearing unseen voices		
Cigarette smoking			Frequent loss of temper		
Tobacco usage			Acting out in violence		
Irritability			Frequent residence changes		
Excessive stress			Frequent employment change		
Crying spells			Bed wetting past age 6		
Phobias or fears			Fire setting past age 6		
Hallucinations			Blaming others frequently		
Confusion			Lack of sexual desire		
Low of self esteem			Spiritual confusion		
Compulsive behaviors			Thoughts of suicide		
Depression			Inability to comprehend reading		
Extreme nervousness			Inability to comprehend math		
Lack of motivation			Inability to express yourself		
Excessive drinking			Involvement with the occult		
Indecisiveness			Use of Pornography		
Loss of memory			Physical abuse of children		
Fantasizing			Sexual abuse of children		
Sexual abuse from others			Physical abuse of others		
Physical abuse of others			Excessive sexual activity		
Abortion			Drug Use / Addiction		
Divorce			Loss of loved one		

Background Information

1. How long has it been since you had a complete physical examination? ________________________

2. Other physical disorders the Counselor should be aware of: ________________________________

____

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PERSONAL HISTORY / BASIC PROBLEM IDENTIFICATION

(Briefly answer the following)

1. DESCRIBE THE PROBLEM THAT BRINGS YOU HERE TODAY:

2. WHAT HAVE YOU DONE ABOUT IT SO FAR?

3. WHAT DO YOU HOPE TO GAIN FROM THIS COUNSELING?

4. WHAT CIRCUMSTANCES HAVE LED TO YOU COMING HERE TODAY?

5. IS THERE ANY OTHER INFORMATION THAT YOU THINK THE COUNSELOR SHOULD KNOW?