Light the Way Christian Counseling Center Intake & Treatment Plan

Intake Date: _____ Referral Source: _____

Name: _____ Birthdate: _____

Address:_____ Phone: _____(H)
_____(W)
_____ _____(C)
_____
_____ _____
Change of Address
_____ Gender: M F
Change of Address

Current Marital Status: ____ Allergies:_____
Emergency Contact: _____ Phone: _____

Other members of the household: _____ age _____
_____ age _____ _____ age _____
_____ age _____ _____ age _____
_____ age _____ _____ age _____

Employment (current):_____
(history): _____
School/Grade: _____

Presenting Problem: (Why today?) _____
_____
_____
_____

Treatment History: (When, why, with whom, what?) _____
_____

Personal Strengths: _____
_____

Social Support System (including activities):_____
_____

Functional Impairments:

Severity Rating: 1= mild 2= moderate 3= severe (how do the symptoms impair functioning or place client at risk)

Area	*Severity*	*Description*
Job/school		
Relationships/ Family		
Other		

Faith Foundation:

Faith History: _____

_____

Level of Spirituality: (low) 1 2 3 4 5 6 7 8 9 10 (high)

Current Risk Factors:

- Suicidality: None ____ Ideation ____ Plan ____ Intent w/o means ____ Intent w/ means ____

_____

- Homicidality: None ____ Ideation ____ Plan ____ Intent w/o means ____ Intent w/ means ____
- If Risk Exists: Client is able to contract not to harm: Self ____ Others ____ Crisis # given: _____
- Impulse Control: Sufficient ____ Moderate ____ Minimal ____ Inconsistent ____ Explosive ____
- Substance Use: None ____ Min/Mod ____ Abuse ____ Dependence ____ Unstable remission ____
- Specify substance(s), quantity, frequency, date of last use, ability to abstain & prior CD treatment:

_____

_____

Significant Social/Family History: _____

_____

_____

_____

_____

_____

Primary Physician: _____

Medical History & Current Concerns: _____

_____

_____

_____

Current Medications: (including prescribing physician & compliance): ____

_____

_____

_____

_____

_____

Mental Status Exam

Dress:	unusual__ unclean __ unkempt __ normal __ other _____
Hygiene:	poor __ fair __ normal __ other _____
Orientation:	person __ place __ time __
Memory:	recent: impaired __ intact __ remote: impaired __ intact __
Sensorium	
Vision:	intact __ impaired __ corrected __
Hearing:	intact __ impaired __ corrected __
Mood	depressed __ blunted __ manic __ angry __ anxious __ appropriate __ inappropriate __
Perception	
Hallucinations:	visual __ auditory __ none __ other _____
Thought Processes:	logical __ loose __ tangential __ rigid __ flights of ideas __ scattered __ delusional (type) __ obsessional __ phobic __ ambivalent __ hopeless __ narcissistic __ persecutory __ other _____
Insight:	poor __ fair __ good ___
Judgement:	poor __ fair __ good __
Motor Behavior:	slowed __ hyperactive __ normal __ other: _____
Speech:	quiet __ pressured __ affected __ normal __ other _____

Treatment Plan

Diagnostic Impressions:

_____ _____(Principal Diagnosis)

_____ _____

_____ _____

Presenting Problem:_____

_____

As Evidenced by:_____

_____

Long-term Goal: _____

Short-term Objective	Strategies	Target Date

Presenting Problem:_____

_____

As Evidenced by:_____

_____

Long-term Goal: _____

Short-term Objective	Strategies	Target Date

Type of Service(s) needed: Individual Therapy _____ Trauma Therapy _____
Family Therapy _____ Group Therapy _____

_____
Therapist

Date: _____

_____
Client

Date: _____

_____
Supervisor where Applicable

Date: _____

A copy of Light the Way client handbook was reviewed and sent home: Y___ N___