



Counseling Intake Form

Please take time to read and answer each question thoroughly - this will greatly help with making the most of your counseling time. When the form is filled, email it to counseling@spokanevbc.org, or drop it off at our office during business hours.

Counseling Agreement

Please indicate that you have read, understood, and agreed with each of the following by initialing each statement, and then signing and dating below.

- _____ 1. You are voluntarily entering into a Biblical counseling relationship. You understand that this counselor is providing his/her time as an act of Christian ministry in association with Valley Bible Church. You acknowledge that this counselor does not necessarily have any credentialing in secular counseling. The counselor has been recognized and endorsed by the Valley Bible Church Elder Board as gifted in the areas of discernment, exhortation, encouragement, healing, and mercy, and who lives a life above reproach.

- _____ 2. You will be counseled according to the principles found in the Bible, which is inspired by God and profitable for teaching, for reproof, for correction, and for training in righteousness, so that the man of God may be adequate and equipped for every good work (2 Tim 3:16), knowing that in God's divine power He has given to us everything pertaining to life and Godliness (2 Pet 1:3).

- _____ 3. Biblical counseling consists of the giving of Scriptural counsel and the practical application thereof. It is, however, the counselee's full responsibility for how or if they implement that counsel. The faithful completion of any homework assignments is necessary to the effectiveness of counsel.

- _____ 4. Though there are no problems which the Bible fails to answer, your counselor is not infallible, nor does he/she pretend to know all there is to know about specific Biblical teachings or applications. While they are well-equipped and competent to provide spiritual counseling, your counselor will make a point to differentiate between God's commands and their own suggestions. Counselors will honestly tell you if they, for any reason, feel that they cannot provide adequate counsel.

- _____ 5. Counseling sessions may be recorded. These recordings are used primarily as a note-taking aid for the counselor, and will not be shared without my permission. The recordings will be made available to me upon request.

- _____ 6. While confidentiality is an important aspect of the counseling process, complete and absolute confidentiality in all cases is not scriptural. Valley Biblical Counseling Center will carefully guard the information you entrust to us to the extent that the Bible and lawful authorities require. Your counselor reserves the right to consult with other members of the VBC counseling ministry for the purpose of providing the highest level of care within the ministries of the church. Counseling involving the persistent refusal to renounce a particular sin may require the disciplinary involvement of the church. If you are a member of another church, we will disclose information about the counseling to your pastor or church leaders only to the extent that you agree, or that is necessary for your spiritual care according to the Bible.

I have read, understood, and agreed to each of the above statements, as noted by my initialing each item.

I further agree not to hold the counselor, Valley Biblical Counseling Center, Valley Bible Church, or Valley Bible Church's leadership financially or legally responsible for the results of the counsel provided or for any decisions I make on the basis of that counsel.

Signed _____ Date _____

Parent/Guardian _____ Date _____



Are you currently suicidal? Yes No Do you feel you might be a risk to yourself or others? Yes No

Have you seriously considered suicide within the last 3 months? Yes No

Personal Information

Name: _____ Gender: Male Female Age: _____

Address: _____ City/State/Zip: _____

Phone #: _____ Email: _____

Occupation: _____ Avg. Hours per week: _____

Highest Level of Education: _____ School: _____

With whom do you currently live? Please check all that apply:

Alone Parents Spouse Children Significant Other (S.O.) Other: _____

Marriage & Family Information

Name of Spouse/Significant Other: _____ Age: _____

Phone #: _____ Email: _____

Occupation: _____ Avg. Hours per week: _____

Highest level of education: _____ Current or most recent school: _____

Is he or she willing to join you for counseling? Yes No Uncertain

Date of wedding: _____ Age at time of marriage: Husband: ____ Wife: ____

Did you live (or are you currently living) together prior to marriage? Yes No

Have you ever been separated? Yes No Currently When/how long? _____

Have you ever been unfaithful to your spouse? Yes No Have either of you been previously married?

Have your spouse ever been unfaithful to you? Yes No Myself Spouse/S.O. Both Neither

Child's Name	Age	Gender	PM/A/D*	Child's Name	Age	Gender	PM/A/D*
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> PM <input type="checkbox"/> A <input type="checkbox"/> D			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> PM <input type="checkbox"/> A <input type="checkbox"/> D
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> PM <input type="checkbox"/> A <input type="checkbox"/> D			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> PM <input type="checkbox"/> A <input type="checkbox"/> D
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> PM <input type="checkbox"/> A <input type="checkbox"/> D			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> PM <input type="checkbox"/> A <input type="checkbox"/> D
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> PM <input type="checkbox"/> A <input type="checkbox"/> D			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> PM <input type="checkbox"/> A <input type="checkbox"/> D
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> PM <input type="checkbox"/> A <input type="checkbox"/> D			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> PM <input type="checkbox"/> A <input type="checkbox"/> D

*Mark if child is product of previous marriage (PM), adopted (A), or deceased (D)



Briefly describe your family upbringing:

Religious Background

Church: _____ Years Attended: _____

Pastor's Name: _____ Church Phone #: _____

May we call the pastor the pastor of your church to coordinate your spiritual care? Yes No

How often do you attend per month? _____ Are you part of a small group? Yes No

Do you and your spouse attend church together? Yes No N/A

Do you and your spouse openly discuss and encourage one another in your faith? Yes No N/A

Please list any ministry involvement: _____

Do you pray to God? Yes No How often do you pray? _____

What do you pray about? _____

Do you read the Bible? Yes No How often do you read it? _____

Do you know Jesus Christ personally as your savior? Yes No Uncertain

If you were to die and stand before God, and He asked you why He should permit you to enter heaven, what would you say?

Favorite Christian authors/podcasters/etc. _____

How would you describe your relationship with God right now? Check all that apply:

Growing Distant Thriving Dry Stagnant Painful Confusing Angry Changing

Other: _____

My most pressing question about the Christian life is... _____



Health/Medical Background

Have you had counseling before? Yes No Have you seen a psychiatrist before? Yes No Currently

Counselor/Psychiatrist	Year	Duration	Issues/Topics/Diagnosis

Do you currently have a primary care physician? Yes No

When was the last time you had a medical physical which included labs? _____

Are you currently under the care of any other doctor, besides your PCP? If so, please list their specialties:

Any current major illness, injury, or disability: _____

How would you describe your overall health? Good Average Declining Other _____

How many hours of sleep do you get each night, on average? _____

Has your sleep changed recently? If so, in what way? _____

Has your weight significantly changed recently? If so, in what way? _____

Please list any medication or supplements you are currently taking:

Medication	Dosage	Frequency	Prescribed for...	Date started...

Have you used drugs for something other than prescribed purpose? Yes No

If yes, please describe: _____

Do you drink alcohol? Yes No Do you use marijuana? Yes No Do you use tobacco? Yes No

If yes to any of the above, please describe (amount, frequency, reason, etc.)



Have you ever used illegal drugs? Yes No

If yes, please list which drugs, what time periods you used them, and the date of last use:

Substance	Frequency	Period of use	Last used

Personal History and Reason for Counseling

Rate the following struggles you are experiencing *at this time*. 1 if mild | 2 if moderate | 3 if severe

Abuse, Physical	Fear	People Pleasing
Abuse, Sexual	Financial Management	Perfectionism
Abuse, Verbal	Forgiveness	Pornography
Abuse in Past	Greed	Pre-Marital Sex
Addiction	Grief	Pride
Anger	Guilt	Priorities
Anxiety	Homosexuality	Procrastination
Apathy	Humility	Purpose, Lack of
Bad Memories	Identity	Rebellion
Bitterness	Impatience	Regrets
Caring for Parents	Infertility	Rejection
Chronic Pain	Insecurity	Relationships
Communication, affection	In-Law Conflict	Respecting Authorities
Communication, day to day	Jealousy	Respecting Parents
Communication, emotions	Judgmental	Respecting Spouse
Communication, planning	Leadership	Same Sex Attraction
Communication, problem	Lifestyle Change	Self-Control
Compulsions	Loneliness	Self-Injury
Conflict Resolution	Lying	Selfish
Depression	Manipulation	Shame
Debt	Marital Intimacy	Social Anxiety
Discontentment	Moodiness	Spiritual Growth
Divorce Recovery	Online Sins	Submission
Doubt Salvation	Panic Attacks	Suicidal Thinking
Eating Disorder	Parenting	Time Management
Empty Nest	Parenting Adult Child	Trust
Envy	Peer Pressure	Work Unfulfilling



Have you suffered the loss of someone close to you in the past year?

Have you had any other significant life changes in the last year?

Have you ever attempted suicide or purposefully caused yourself bodily harm? If yes, please explain

Describe in your own words the difficulties or problems that bring you here at this time.

When did these problems begin?



What have you done about the problem so far?

What do you want us to do? What expectations do you have in coming here for counseling?

What do you believe you will have to change in order to see the progress you desire?

Is there any other information not asked elsewhere that you feel we should know?
