NEW ENGLAND PASTORAL INSTITUTE, INC.

5 Summer Street
Lynnfield, MA 01940
603-890-6767

15 Ermer Road, Suite 215
Salem, NH 03079
603-890-6767
FAX 603-893-6767

20 West Park Street, Suite 214
Lebanon, NH 03766
603-448-2414

INTAKE QUESTIONNAIRE – ADULT

Your response to the following questions will help your therapist better understand you and your situation in order to provide the best possible service. Please answer all questions as completely as possible.

Name of person completing form: ______________________ Date: ______________

IDENTIFYING INFORMATION (for individual receiving services)

Name: ______________________ Date of Birth: ______________

Address: ______________________ Gender: ______________

______________________ Relationship Status: ______________

Home Phone: ( ) ______________________ Work Phone: ( ) ______________

Social Security Number: ______________________ Household Income: $ ______________

Who referred you to the New England Pastoral Institute? ______________________

What is your cultural background?

- ☐ White/Caucasian
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ Unknown
- ☐ Non-Hispanic or Non-Latino
- ☐ Asian
- ☐ Black/African American
- ☐ Two or more races
- ☐ Hispanic or Latino
- ☐ Other ______________________

Religious Affiliation:

- ☐ Catholic
- ☐ Muslim
- ☐ Jewish
- ☐ Quaker
- ☐ Protestant: specify denomination ______________
- ☐ Non-Denominational
- ☐ No Affiliation
- ☐ Other: ______________________

Language of Choice ______________________

Disability:

Do you have a disability? ☐ Yes ☐ No If yes, please specify: ______________________

If you have a disability, does the office accommodate your needs? ☐ Yes ☐ No

If yes, please explain: ____

If you feel that the therapist should be aware of any special treatment considerations due to gender, age, sexual orientation or cultural, religious, national, racial or ethnic identity, please explain below:

____
____
____
____
____

GOALS

1. What are your strengths? ____
   ____

2. What are your weaknesses? ____
   ____

3. What goals would you like to see reached as a result of your involvement with NEPI?
   ____
   ____
   ____
   ____

4. How will you know when these goals have been reached?
   ____
   ____
   ____

PRESENTING PROBLEM (current situation and history)

1. What is the primary problem for which you are seeking help? (please circle)

a. Marriage or relationship	g. Problems with children	m. Grieving
b. Family problems	h. Peer problems	n. Abuse or trauma
c. Depression	i. Eating disorder	o. Sexual functioning
d. Mood swings	j. Alcohol/drug use	p. Anger
e. Behavior	k. Physical problems	q. Anxiety or worry
f. Self-confidence	l. Work related	r. Other (explain):

____
____
____

2. How long have you had this/these problem(s)? ____

3. Have you received treatment for this problem or any other problem in the past? ☐ Yes ☐ No

   If yes when, where and with whom? ____

   ____

   ____

   ____

   ____

   ____

   ____

FAMILY HISTORY

1. Were drugs or alcohol a problem in your family when you were growing up? ☐ Yes ☐ No

   If yes, please explain: ____

   ____

   ____

2. Do you or another family member have a history of alcohol or drug problem? ☐ Yes ☐ No

   If yes, please explain: ____

   ____

   ____

3. Please describe your current alcohol consumption: ___________________________________

   ____

4. Was there any type of abuse (physical, sexual, domestic or emotional) in your family or home?

   ☐ Yes ☐ No If yes, please describe the circumstances: ____________________________

   ____

5. Have you or any other family member experienced any type of abuse? ☐ Yes ☐ No

   If yes, please explain: ____

   ____

CURRENT FAMILY INFORMATION

1. Please provide the following information:

Name (First and Last)	**Date of Birth**	**Lives with You?**
Spouse/Significant Other:		Yes No
Children: ______________________________		Yes No
______________________________		Yes No
______________________________		Yes No
______________________________		Yes No
Others Living in Household:		

2. Highest educational level achieved: ______________________________

3. Military service: ☐ Yes ☐ No

   If Yes, please indicate branch of service and dates of service: ______________________________

   If you were deployed, please indicate location(s) of deployment and time(s) of deployment:______________________

   ____

   Please indicate any service-related issues that you want your therapist to know about: ______________________

   ____

   ____

4. Occupation: ____

5. Current employer: ____

LEGAL HISTORY

Please describe any involvement you have had with the legal system (arrests, convictions, probation, parole):

____

____

____

MEDICAL HISTORY

1. Primary Care physician/pediatrician: ____
   Address ____
   ______________________________________ Phone ______________________________

2. Please check the appropriate box if you have experienced any of these problems:

- ☐ Eye disease, injury, poor vision
- ☐ Ear disease, injury, poor hearing
- ☐ Nose, sinus, mouth, throat problems
- ☐ Head injury
- ☐ Convulsions or seizures
- ☐ Memory problems
- ☐ Extreme tiredness or weakness
- ☐ Thyroid disease or goiter
- ☐ Skin disease
- ☐ Heart disease
- ☐ Back, arm, leg or joint problems
- ☐ Blood disease
- ☐ Stomach problems
- ☐ Premenstrual Syndrome (PMS)
- ☐ Eating disorder
- ☐ Liver, gallbladder disease
- ☐ Chest pain or angina pectoris
- ☐ Cancer
- ☐ Bowel problems
- ☐ Hemorrhoids, rectal bleeding
- ☐ Loss of consciousness
- ☐ Frequent or severe headaches
- ☐ Sleep disturbances
- ☐ Neck stiffness, pain, swelling
- ☐ Marked weight changes
- ☐ Circulatory problems
- ☐ Allergies or asthma
- ☐ Diabetes
- ☐ Encephalitis
- ☐ Meningitis
- ☐ Pregnancy not carried to term/stillbirths
- ☐ High blood pressure
- ☐ Other ______________________________

Please explain anything checked above: ____

____

3. Please provide information about medication(s), prescription or over-the-counter, which you take regularly:

Medication	Dosage/Frequency	Prescribing Physician	For what condition?

4. Please list significant hospitalizations, operations, injuries (including broken bones): ___________________

____

____

____

SPIRITUAL/RELIGIOUS HISTORY

1. Did you attend religious services and/or religious education programs as a child? ☐ Yes ☐ No
   If Yes, please describe ____
   ____

2. Have you been (check all that apply) ____Baptized ____ Confirmed ____Bar/Bat Mitzvah
   ____ Other (Please describe) ____

3. If you are, or have been married, did your ceremony(s) take place in a house of worship? ☐ Yes ☐ No

4. Please check any of the following religious/spiritual resources that you presently practice:

☐ Religious services: ____ x Week Month Year (circle one)	☐ Prayer
☐ Meditation	☐ Yoga
☐ Bible Study	☐ Read Scripture
☐ Serve a Mission Project	☐ Retreats
☐ Volunteer at my place of worship	☐ Discussion Group
☐ Read religious/spiritual books	☐ Spend time in nature
☐ Take courses on religious/spiritual topics	☐ Participate in worship music programs
☐ Other ________________________________	☐ Other ________________________

5. What words would you use to describe God ____
   ____

6. Have you experienced any crisis of faith, times of doubt, alienation from God or your religious community?
   ☐ Yes ☐ No
   If Yes, please describe ____
   ____
   ____

7. Have you had a Conversion Experience, been Saved or been Born Again? ☐ Yes ☐ No
   If Yes, please describe ____
   ____
   ____

THERAPIST REVIEW

Signature: ______________________________ Date: ____________________