MUSLIM COUNSELING INTAKE FORM

Please fill out the entire form so we can get to know you better and help you most effectively. However, your comfort is our priority. Feel free to fill out only the information you would like to share with us and leave the rest of the form blank.

Let us get to know you so we can serve you most effectively!

**** Required Field***

***Name:**			
***Phone**		***Gender: Male / Female**	
***Age:**		***E-mail**	
***Home Address**			

Primary reason(s) for seeking services at this time (please check all that apply):

- ☐ Premarital Counselling
- ☐ Marital Counselling
- ☐ Family Counselling
- ☐ Parental Counselling
- ☐ Other (specify):
- ☐ Other _____

Current Life Stressors (please check all that apply)

- ☐ Children
- ☐ Finances
- ☐ Legal Issues
- ☐ Environment
- ☐ Health
- ☐ Relationship
- ☐ Family
- ☐ Job
- ☐ School
- ☐ Other _____

Relationship and Family Information

Relationship Status

- ☐ Single
- ☐ Engaged
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Other _____

Assessment of current relationship (if applicable):

- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Other _____

Have you experienced physical, sexual, emotional, economic or psychological abuse in current or past relationships?

- ☐ Yes
- ☐ No
- ☐ Other: _____

Social Relationships

Check how you generally get along with other people: (check all that apply)

- ☐ Affectionate
- ☐ Aggressive
- ☐ Avoidant
- ☐ Fight/Argue Often
- ☐ Follower
- ☐ Friendly
- ☐ Leader
- ☐ Outgoing
- ☐ Shy/Withdrawn
- ☐ Submissive
- ☐ Other (specify): _____

Is there anyone in your life that you feel you can talk with about your situation?

- ☐ Yes
- ☐ No
- ☐ Other:

Religion

Do you believe Islam is an integral part of your life?

- ☐ Yes
- ☐ No
- ☐ Other:

Are you content with your level of activity in regards to your spiritual development?

- ☐ Yes
- ☐ No
- ☐ Other:

Is it important for you to raise your family in a religious environment?

- ☐ Yes
- ☐ No

How would you describe your level of Islamic knowledge?

Employment
Are you currently employed?

- ☐ Yes
- ☐ No
- ☐ Employed Full Time
- ☐ Employed Part Time
- ☐ Seasonal Employment
- ☐ Disabled
- ☐ Retired
- ☐ Student
- ☐ Other: _____

Medical/Physical Health
List any current physical health concerns:

Family history of medical problems (describe):

Current prescribed medications

Dose

Purpose

Side Effects

Have you ever had a head injury?

- ☐ Yes
- ☐ No

Do you have a current issue or history of self-injury (cutting, burning, etc.)?

- ☐ Yes
- ☐ No

Please check if there have been any recent changes in the following:

- ☐ Sleep patterns
- ☐ Eating patterns
- ☐ Behavior
- ☐ Energy level
- ☐ Physical activity level
- ☐ General mood
- ☐ Weight
- ☐ Nervousness

For Official Use Only

Form received on:	
Donation Optional	Receipt Number:
Approved	☐ Yes ☐ No, Reason:
Name and Signed	

Date for Consultation:

Date:	
Time:	