SoulCare Counseling Client Intake

Client Information and History

Name: ◯ **Male** ◯ **Female**

Birth Date: **Age:**

Street Address:

City: **State:** **Zip Code:**

Home Phone: **Work:** **Mobile:**

Email:

How do you prefer to be contacted? ☐ **Phone** ☐ **Text** ☐ **Email**

Employer: **Position:**

Education Level: Choose One

Emergency Contact Name:

Emergency Contact Phone:

How did you learn about SoulCare Counseling? Choose One

Referred by: Choose One

What problem/issue brings you to counseling? Choose One

How have you tried to resolve the problem?

What do you expect from counseling for this issue?

Health Information

List your current medications:

Medication	Dosage	Taken for how long?

Primary Care Physician: **Phone:**

Psychiatrist: **Phone:**

Current health problems:

Past health problems:

Current mental health problems:

Past mental health problems:

Are you seeing another therapist? ◯ **Yes** ◯ **No**

For what reason? **How long?**

Ever been admitted to a psychiatric or substance abuse facility? ◯ **Yes** ◯ **No**

For what reason? **When?**

Indicate if you have used any of these substances:

Substance	Last Time Used	Amount
Alcohol ☐		
Pain Relievers ☐		
Marijuana ☐		
Cocaine or Heroine ☐		
Crystal Meth ☐		
Other illegal drugs ☐		

Rate your experience of these thoughts and behaviors:

Hard to fall or stay asleep	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Sleep too much	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Change in appetite	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Change in weight up/down	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Frequent crying spells	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Nausea, Vomiting, Diarrhea	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Suicidal thoughts	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Suicidal plans/intentions	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Homicidal thoughts	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Homicidal intentions	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Self-harm (cutting, inducing vomiting/bowel movements)	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Isolating from family/friends	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Trouble concentrating on daily living or work tasks	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Difficulty remembering names/dates/directions/events	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Easily startled/jumpy	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Flashbacks of a trauma	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Sense that something bad happened but can't recall it	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Uncontrolled anger, irritable	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Verbally, physically abusive	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Get in arguments/conflict with family or co-workers	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Feeling at end of your rope	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Angry when people don't cooperate or agree with you	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Mood swings	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Seeing things others don't	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Hearing things others don't	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
People are talking about me	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
People are out to get me	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Feeling tired almost daily	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Low/No interest in sex	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Viewing Pornography	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Soliciting sexual encounters via text, email, internet	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Depressed when criticized	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Avoiding situations where you have to talk to strangers	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Difficulty making decisions on how to start/complete task	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**
Trouble discarding things	☐ **Mild/None**	☐ **Moderate**	☐ **Severe**

Marriage and Family Information

Your Marital status: Choose One

Name of spouse: **Length of marriage:**

Age when married: Husband **Wife**

In your current marriage, have you ever separated? ◯ **Yes** ◯ **No**

Number of times? **For how long?**

Reason:

Are you currently separated? ◯ **Yes** ◯ **No**

Is there currently domestic violence? ◯ **Yes** ◯ **No**

Describe:

Has there been domestic violence in the past? ◯ **Yes** ◯ **No**

Describe:

Has there been physical or emotional infidelity? ◯ **Yes** ◯ **No**

By which partner?	When?	How long did it last?

Previous marriages:

How many?	Length of marriage	Reason it ended	Number of children

Spouse's previous marriages:

How many?	Length of marriage	Reason it ended	Number of children

Number of dependent children: Choose One

Number of children: **Have you had any children die?** ◯ **Yes** ◯ **No**

How?

Children living at home:

Names of children at home	Ages	Sex	Any Problems?

Do you feel emotionally close to your spouse? ◯ **Yes** ◯ **No**

Do you feel safe/secure in your marriage? ◯ **Yes** ◯ **No**

If not, why not?

Were there times in the past when you felt close to your spouse? ◯ **Yes** ◯ **No**

Describe when you felt close. (e.g., early days, during a crisis, after making up, etc.)

Have there been any traumatic incidents in your marriage when you felt your spouse was not there for you? ◯ **Yes** ◯ **No**

Describe:

How do you view your spouse?

How do you think your spouse views you?

Family Background Information

How many brothers and/or sisters do you have? Brother(s) Sister(s)

Where are you in the birth order?

Were you physically abused as a child or teenager? ◯ Yes ◯ No

By whom?

At what age did it begin? At what age did it stop?

What brought it to an end?

Have you ever told anyone before now? ◯ Yes ◯ No Who?

What was their response?

Have you ever gone to counseling to cope with your abuse? ◯ Yes ◯ No

Were you sexually abused as a child or a teenager? ◯ Yes ◯ No

By whom?

At what age did it begin? At what age did it stop?

What brought it to an end?

Have you ever told anyone before now? ◯ Yes ◯ No Who?

What was their response?

Have you ever gone to counseling to cope with your abuse? ◯ Yes ◯ No

What was it like growing up in your home?

Happy ☐	**Warm** ☐	**Fun** ☐	**Close** ☐	**Angry** ☐
Fearful ☐	**Shameful** ☐	**Safe** ☐	**Relaxed** ☐	**Blaming** ☐
Critical ☐	**Cold** ☐	**Distant** ☐	**Strict** ☐	**Tolerant** ☐
Punishing ☐	**Controlling** ☐			

Who had the power/control in your home/made most of the decisions?

Who administered discipline? Type of discipline:

Describe your mother:

Describe your father:

What was their relationship like?

Describe your relationship with your mother:

Describe your relationship with your father:

Were your parents accessible to you when you were growing up? If you were upset, were you able to get their <u>kind</u> attention easily? ◯ **Yes** ◯ **No**
Say a little more:

Were your parents responsive to you? Would they comfort you if you were upset, sick, or hurt and validate your feelings and experiences? ◯ **Yes** ◯ **No**
Say a little more:

Were your parents engaged with you? ◯ **Yes** ◯ **No**

Did you feel heard and understood by your parents? ◯ **Yes** ◯ **No**

Say a little more:

Religious/Spiritual Background

Do you attend church? ◯ **Yes** ◯ **No**

How often? Choose One

Did you attend church as a child or teenager? ◯ **Yes** ◯ **No**

Were you made to go, or did you want to go? Choose One

Are you a Christian? ◯ **Yes** ◯ **No** ◯ **Unsure**

If so, how old were you when you became a Christian?

If so, briefly describe your conversion experience:

Are you satisfied with your relationship to God? ◯ **Yes** ◯ **No**

Say a little more:

Is this an area of your life that you would like to improve? ◯ **Yes** ◯ **No**

What would you like to see change concerning your relationship to God?

How do you think counseling can help you with your spiritual problems?

What issues are you currently struggling with in your relationship with God?

What is your spouse's religious background?

Do you attend church together? ◯ **Yes** ◯ **No**

How often? Choose One

What is your spiritual relationship like with your spouse? Choose One

Is this an area of your marriage that causes problems? ◯ **Yes** ◯ **No**

How?