



SoulCare Counseling • 1706 Tennon Pkwy, #140 • Colleyville, TX • 76034
817.808.2606

Client Information and History

Name: _____ Male Female

Birth Date: _____ Age: _____

Address: _____
(street) (city) (zip code)

Phone: _____ (home) _____ (work) _____ (cell)

Email: _____

How do you prefer to be contacted? (check all that apply):

Phone call: _____ Text message: _____ Email: _____

Marital status: _____ If married, for how long? _____

Spouse's name/age: _____ Number of dependent children _____

Employer: _____ Position: _____

Education: _____

Emergency contact name and phone #: _____

How did you learn about SoulCare Counseling? Circle all that apply:

Mailer Flyer Brochure Signage
Website Psychology Today Facebook YouTube
Friend/neighbor Pastor/church leader Doctor Counselor
Other _____

If a pastor/church leader or a doctor or counselor referred you, may we send a note of appreciation? Yes No

For what problem(s) or issue(s) are you seeking counseling at this time?

What have you done so far to handle or resolve the problems or issues?

What do you expect from counseling regarding this problem?



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Medical Information and Health History

Please list all of your current medications and dosages:

<u>Medication</u>	<u>Dosage</u>	<u>Length of time</u>
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- 1.
- 2.
- 3.
- 4.
- 5.

Primary care physician _____ Phone _____

Psychiatrist _____ Phone _____

Please list all current health problems and any serious past health problems

1. _____
2. _____
3. _____
4. _____
5. _____

Please list all current and past mental health problems for which you have sought treatment, i.e. depression, mood swings, substance abuse, anxiety, anger, abuse, trauma

1. _____
2. _____
3. _____
4. _____

Are you currently seeing another therapist? _____ If so, for what reason and how long?

Have you ever been admitted to a psychiatric or a substance abuse facility? _____ If so, for what reason and when?



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Please circle any substances you currently use and give the amount you use each day

<u>Substance</u>	<u>Amount each day</u>
Cigarettes	_____
Alcohol	_____
Non-prescription pain relievers	_____
Prescription pain relievers	_____
Pills not prescribed for me	_____
Marijuana	_____
Cocaine or crack	_____
Crystal Meth	_____
Other illegal drug(s)	_____

Please indicate if you are having any of the following problems:

- ___ Difficulty falling asleep or staying asleep
- ___ Sleeping too much
- ___ Change in appetite: increased or decreased
- ___ Rapid change in weight: lost gained How much? _____
- ___ Vomiting, nausea, or diarrhea several times a week
- ___ Frequent crying spells
- ___ Panic attacks or anxiety attacks
- ___ Suicidal thoughts ___ Suicide plans/intentions
- ___ Homicidal thoughts ___ Homicidal intentions
- ___ Self-harming behaviors (cutting, inducing vomiting or bowel movements)
- ___ Problems concentrating or focusing on daily living tasks or work-related tasks
- ___ Difficulty remembering names, important dates, directions, or recent events
- ___ Easily startled or jumpy
- ___ Recurring flashbacks of traumatic past events
- ___ A vague sense that something bad happened in the past, but unable to recall it
- ___ Difficulty controlling anger or easily "ticked-off"
- ___ Verbally or physically abusive (yelling, calling names, hitting, slapping, kicking)
- ___ Frequent arguments/conflict with family members or co-workers
- ___ Feeling like "I just can't stand this any longer"
- ___ Feeling enraged when people don't cooperate with you or agree with you
- ___ Mood swings
- ___ Seeing things or hearing things that other people don't see or hear
- ___ Hearing voices inside your head
- ___ Thinking that other people are talking bad about you or are planning to get you
- ___ Feeling tired almost everyday
- ___ Little or no interest in sex
- ___ Obsessed with sex (masturbating 4-5 times per week, viewing pornography daily)
- ___ Feeling depressed when criticized
- ___ Avoid situations where you would have to talk to people you don't know
- ___ Difficulty making decisions on how to start or complete a task
- ___ Unable to discard things which are no longer needed (newspapers, magazines)



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Marriage and Family Information

Current marital status: married engaged co-habiting separated single
(If single, you may skip the following questions)

Name of spouse: _____ Length of marriage? _____

Ages when married: Husband ____ Wife ____

How many times have you been married before? _____

How many times has your spouse been married before? _____

In your current marriage, have you ever been separated? _____ How many times? _____

For what reason did you separate? _____

How long were you separated? _____ Are you currently separated? _____

Is there domestic violence currently? _____

Please describe: _____

Have there been any incidents of domestic violence in the past? _____

Please describe: _____

Do you feel emotionally close to your spouse and safe/secure in your marriage? _____

If not, why not? _____

Give brief information about your previous marriages such as length of marriage, reason for divorce, and any children born from those previous marriages:

How many children do you have? _____

Have you had any children die? _____ Please explain: _____

How many children are living in your home? _____

Please list first and last name of each child, age, sex, and any current problems.

* If you are currently married/engaged, please answer the following questions:

Have there been times in the past when you have felt close to your spouse? _____

If so, can you describe when you felt close? i.e. beginning of relationship, after a crisis, making up after a fight, etc.... _____

Have there been any particular traumatic incidents in your marriage where you felt your spouse was not there for you? If so, please describe: _____

How do you view your spouse? _____

How do you think your spouse views you? _____



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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 ever physically abused as a child or teenager? _____
By whom? _____
At what age did it begin and how old were you when it stopped? _____
What brought it to an end? _____
Have you ever told anyone before now? _____ Who? _____
What was their response? _____
Have you ever gone to counseling to cope with your abuse? _____

Were you ever sexually abused as a child or a teenager? _____
By whom? _____
At what age did it begin and how old were you when it stopped? _____
What brought it to an end? _____
Have you ever told anyone before now? _____ Who? _____
What was their response? _____
Have you ever gone to counseling to cope with your abuse? _____

What was it like growing up in your home? Circle all that apply:
happy warm fun close angry fearful shameful safe relaxed
blaming critical cold distant strict tolerant punishing controlling
other _____
Who had the power and control in your home, i.e. who made most of the decisions?

How would you describe your mother?

How would you describe your father?

What was your relationship like with your mother while growing up?

What was your relationship like with your father while growing up?

Who did you go to for comfort/safety when you were young?

Could you depend on this person(s) for comfort/safety? i.e. were they readily responsive?

When were you most likely to be comforted by this person(s)?

How did you let this person(s) know that you needed comfort and connection?



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Religious/Spiritual Background

Do you currently attend church? _____

How often? _____

Did you attend church as a child or as a teenager? _____

Were you made to go by your parents or did you go because you wanted to? _____

Are you a Christian? _____

How old were you when you became a Christian? _____

If so, briefly describe your conversion experience: _____

Are you satisfied with your relationship to God? _____

Why or why not? _____

Is this an area of your life that you would like to improve? _____

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? Explain:

What is your spouse's religious background? _____

Do you attend church together? _____

How often? _____

What is your spiritual relationship like with your spouse? _____

Is this an area of your marriage that causes problems? _____

If so, how? _____