Soul Purpose Counseling

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Client Intake Information

Please provide the following information. Provided responses will be protected as confidential information. The completed form is to be brought to your first session.

Name: _____ _____ _____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status: □ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Please list any children/age(s): _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: _____ May we leave a message? □ Yes □ No

Cell/Other Phone: _____ May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No

Emergency Contact Name and Telephone Number: _____

_____

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist / practitioner: _____

Are you currently taking any prescription medication?
□ Yes
□ No
If yes, please list: _____

Have you ever been prescribed psychiatric medication?
□ Yes
□ No
If yes, please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle):

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

_____

_____

3. Please list any difficulties you experience with your appetite or eating patterns:

_____

4. Have you experienced significant physical illness (e.g. heart disease/condition, cancer, diabetes, other potentially life-threatening conditions)? If so, please describe and give approximate dates:

_____

_____

_____

5. Please describe your history of past surgical procedures (type of surgery and approximate date):

_____

_____

_____

6. Are you currently experiencing sadness, grief, or depression?
□ No
□ Yes
If yes, for approximately how long? _____

7. Are you currently experiencing anxiety, panic attacks, or have any phobias?
□ Yes
□ No
If yes, when did you begin experiencing this?

_____

8. Are you currently experiencing any chronic pain?
□ Yes
□ No
If yes, please describe: _____

9. Do you drink alcohol more than once a week? □ Yes □ No

10. How often do you engage recreational drug use? (Please Circle)

Daily Weekly Monthly Infrequently Never

11. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

12. What significant life changes or stressful events have you experienced recently:

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	Yes/No	
Anxiety	Yes/No	
Depression	Yes/No	
Bipolar Disorder	Yes/No	
Domestic Violence	Yes/No	
Eating Disorders	Yes/No	
Obesity	Yes/No	
Obsessive Compulsive Behavior	Yes/No	
Schizophrenia /Psychosis	Yes/No	
Suicide Attempts	Yes/No	

GENERAL

Are you currently employed? □ No □ Yes

If yes, what is your current employment situation?

_____

_____

_____

Do you enjoy your work? _____

Is there anything stressful about your current work?

_____

_____

_____

What is the role of religion / spirituality in your life?

_____

_____

_____

What do you consider to be some of your strengths?

_____

_____

_____

What do you consider to be some of your weaknesses?

_____

_____

_____

What would you like to accomplish out of your time in therapy?

_____

_____

_____