Soul Care Psychotherapy

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Intake Form

Welcome. Please share the information below to aid me in understanding you and your concerns. Complete the form as thoroughly as possible. All information will be held confidentially, as explained in my disclosure statement and office policies.

Name: _____ **Age:** _____ **Birth Date:** _____
Address: _____ **City:** _____ **State:**_____ **Zip:** _____
Phone Numbers: Home: _____ **Work:** _____ **Cell:** _____
Employer or School: _____ **Occupation:** _____ **Education Level:** _____
Race/Nationality/Ethnic Origin: _____ **Who referred you to me for psychotherapy?** _____

Relationship Status:

Never Married: _____
Married: _____ **Dates:** _____
Living w/Partner:_____ **How Long?** _____
Separated: _____ **How Long?** _____
Widowed: _____ **How Long?** _____
Divorced: _____ **How Long?** _____

Sexual Orientation:

Heterosexual _____
Gay _____
Lesbian _____
Bisexual _____
Transgendered _____

List any previous marriage partners, or significant relationships, with dates: _____
_____

If married or in a committed partnership:

Spouse/Partner's Name: _____ **Age:** _____ **Birth Date:** _____ **# Years Together:** _____
Employer or School: _____ **Occupation:** _____ **Education Level:** _____
Race/Nationality/Ethnic Origin: _____ **Previous marriage partners, or significant relationships, (please include dates):**_____

Children/Stepchildren:

Name:	Age:	Birth Date:	Sex:	Relationship to You?	Living With You?

Have you had a child die? _____ **Miscarriages:** _____ **Abortions:** _____

Family Background:
Parents' Names/Ages: _____
Are/Were your parents married? _____ **Date(s):** _____ **Are/Were your parents divorced?** _____ **Dates:** _____
Were you adopted? If yes, at what age? _____ **Stepparents?** _____
Siblings' Names & Ages (include step and half siblings): _____
_____
Have any parents or siblings died? (Indicate name, cause of death, date):_____

Physical/Emotional Health:
Have you received previous psychotherapy or counseling? _____ **If yes, from whom, and when?** _____
_____
Have you ever attempted suicide? _____ **If yes, at what age(s)?** _____
Physician's Name(s), with Phone #'s: _____
_____
List any medications, supplements, herbs, or homeopathic treatments you are taking, condition you are taking them for, dosage, & who prescribed: _____
_____

Intake Date: _____

Other health conditions:_____
Do you currently, or have you in the past had a problem with alcohol or drug abuse? If so, please explain: _____
_____

What do you believe is your* physical *condition at this time?
Poor ____ Fair ____ Average ____ Good ____ Excellent ____
What do you believe is your* emotional *condition at this time?
Poor ____ Fair ____ Average ____ Good ____ Excellent ____

Which of the following describe or relate to the concerns which bring you to therapy?

Alcohol Problems	_____	**Anxiety**	_____	**Abuse Survivor:**	
Drug Problems	_____	**Relationship with:**		**Sexual**	_____
Anger	_____	**Partner**	_____	**Emotional**	_____
Depression	_____	**Parents**	_____	**Physical**	_____
Loneliness	_____	**Children**	_____	**Abuse Perpetrator:**	
Guilt	_____	**Coworkers**	_____	**Sexual**	_____
Sexual Concerns	_____	**Others**	_____	**Emotional**	_____
Fear	_____	**Elevated Mood**	_____	**Physical**	_____
Grief	_____	**Hopelessness**	_____	**Eating/Food Issues**	_____
Midlife Issues	_____	**Sleep Problems**	_____	**Self-Doubt**	_____
Suicidal Feelings	_____	**Strange Thoughts**	_____	**Legal Issues**	_____
Spiritual Issues	_____	**Finances**	_____	**Work Issues**	_____
Physical Health	_____	**Self-Esteem**	_____	**Loss of Interest**	_____

State in your own words what brings you to therapy: _____
_____
_____
_____

What do you hope to achieve in therapy (goals/focus areas/expectations)?_____
_____
_____
_____

Religious and/or Spiritual Information:

For some clients, attention to the spiritual dimension of their lives is an important part of the therapy process. Others have had questions, doubts, or painful experiences associated with their faith life. For still others, these issues are not important. The following questions are meant to help me understand these dimensions of your life as fully as possible. Please answer them so I may serve you in the most helpful and respectful manner possible, and so that I may better understand your unique perspective and needs.

Religious/Spiritual Affiliation (if any): In childhood: _____ **As an adult:** _____

Favorite "sacred story" (e.g., from the Bible or other religious tradition): In Childhood: _____ **As an adult:** _____

Is religion/spirituality an important part of your life? _____ **Do you believe in God, or in some kind of Divine Presence?** _____

Do you pray or meditate? _____ **Do you read Sacred Scriptures (Bible, Torah, Koran, course in Miracles, etc.?)** _____

Have you had any unusual/remarkable spiritual experiences? _____
_____

Have you had times when you have felt distant from, angry at or confused about God?_____
_____

Have you ever felt extremely close to God or a Divine Presence? _____
_____

Have you had recent changes in your religious/spiritual life? _____
_____

What is your favorite myth or fairy tale? _____

Who is your favorite hero/heroine, or whom do you admire most? _____

What is your favorite movie? _____

Intake Date: _____