Soul Care Psychotherapy

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Intake Form

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: ☐ **Separated:** ☐ **How Long?** _____________
Married: ☐ **Dates:** ________________ **Widowed:** ☐ **How Long?** _____________
Living w/Partner:_☐ **How Long?** ____________ **Divorced:** ☐ **How Long?** _____________

Please list previous marriages and/or significant relationships:

____

Current Spouse/Partner's Name: _________________________________ **Age:** __________ **Birth Date:** _________________

Employer or School: _________________________ **Occupation:** ______________________ **Education Level:** _____________

Race/Nationality/Ethnicity: ________________________________ **Phone Number:** _____________________________

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: ____

Medications, supplements, etc. you are taking, conditions you're taking them for, dosage, & who prescribed?:

____

Do you currently, or have you in the past had a problem with alcohol or drug addiction? If so, please elaborate:

____

Do you identify as: ☐ **Straight** ☐ **Gay** ☐ **Lesbian** ☐ **Bisexual** ☐ Non-Binary ☐ Transgendered ☐ **Other:** ______________________

What pronouns do you prefer? ☐ **She/her/hers** ☐ **He/him/his** ☐ **They/them/theirs** ☐ **Other: Please specify:** ________________________

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 & Spiritual Information:

For some people, the spiritual dimension of life is an important part of therapy. Some have had questions, doubts, or painful experiences in their faith or spiritual life. For others, these issues are not important. These questions will help me understand your unique perspective and needs.

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

Favorite "sacred story/stories" (e.g., from the Bible, Torah, Koran, or other tradition): ____

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 else is important for me to know about the religious or spiritual dimensions of your life? ______________________________________

____

What/Who is your favorite: Myth/fairy tale? _____________________________________ **Movie?** ____________________________________

Hero/Heroine (or, who you admire most?) _____________________________ **Musician/Band/Performer** _____________________________

IF INSURANCE WILL BE USED, FILL IN THIS SECTION:

Primary Insurance Company____ **Insurance ID#:** ______________________

Group Number:_________________________ **Your Relationship to Insured:** ☐ **Self** ☐ **Spouse/Partner** ☐ **Child**

Secondary Insurer (if applicable): ____ **ID#:** ____________________________

Other Insured's Name (Insurance Policy Holder): Last:__________________________________ **First:** _____________________

Other Insured's Address:____________________________________ **City:**_____________________ **State:**_______ **Zip:** __________

Insured's Date of Birth:______________ **Other Insured's Employer:** ____

Intake Date: ____________________