HOPE FOR THE SOUL

Client Intake Form

Name_____ Age _____ Date_____/_____/_____

How did you hear about us?_____
What prompted your visit?_____
_____
How long have you been struggling with this issue/concern? _____
What are three goals/areas you wish to work on?

1. _____
2. _____
3. _____

What are your greatest strengths? _____
_____

Educational/Vocational Background
What is the highest level of education you have completed? _____
Did you earn a degree? If so, in what?_____

Please indicate your work or military history in the past 10 years

Dates	Job Title	Reason for leaving	Job satisfaction

Are there any problems or relational conflicts at your current job? If yes, please describe:
_____
_____
Please describe any volunteer experience: _____
_____

Mental/Medical History
Have you ever received counseling services before?

Counselor Name	Dates	Reason	Outcome

What approaches/self-care have you tried in the past on your own?_____
_____
Were any of them successful?_____

Please list any medication you are currently taking:

Medication	Dates	Dosage	Reason	Physician

Compliance: □yes □no □partial

Date of last medical examination _____/_____/_____ Primary Physician_____
Address _____ Phone _____

Please rate your health: Excellent_____ Good _____ Fair _____ Declining _____ Poor _____
Please list all current or previous ongoing or acute illnesses, injuries, handicaps, hospitalizations, and medical concerns:_____
_____
_____

Have you noticed any disturbance in sleep, weight, eating habits, mood, concentration, energy, memory, social interactions, and daily functioning? Please describe in as much detail as possible: _____
_____
_____
_____

Please describe your current sleep and eating habits _____
_____

Are you currently drinking alcoholic beverages? Y N If yes, please indicate how much and how often:
_____

Have you ever tried to cut back on your consumption? If yes, when and were you successful?
_____

Are you using any illegal drugs/substances? If yes, please describe _____
Have you abused any other substance before? If so what? _____
_____

Social/Family Background

Is your father living? Y N Age_____ Marital Status _____ Date of Death (if applicable)_____
Please describe your current and past relationship with your father: _____
_____
_____

Is your mother living? Y N Age_____ Marital Status _____Date of Death (if applicable)_____
Please describe your current and past relationship with your mother:_____
_____
_____

Siblings (please indicate whether B(bio), S(step), H(half), A(adopted), etc. in relationship column)

Name	Age	Relationship to You	Location	Year Deceased (if applicable)

What is your relationship with your sibling(s) like?_____
_____

Please describe any mental illness, medical problems, handicaps, addictions, suicide, or abuse in your family history:
_____
_____
_____

What is your earliest childhood memory?_____
_____

What is your favorite childhood memory?_____
_____

What is your worst childhood memory? _____
_____

Marital Relationship: □ Never Married

	First Marriage	Second Marriage	Third Marriage
Date:			
Separated (year):			
Divorced (year):			
Widowed (year):			

How satisfied are you with your current relationship status?
Very happy _____ Happy _____ Indifferent _____ Unhappy _____ Totally Miserable _____
Please explain in detail: _____

_____

If married, did both of you have your parents' blessing? Y N
If no, please explain: _____

_____

Are you currently sexually active? Y N Are you satisfied with it? Y N
When was your first sexual experience?_____ Was it consensual? Y N Was it as you had hoped? Y N
Why or why not?_____
Do you engage in any other sexual behaviors? If yes, please explain: _____

_____

How would you describe your present feelings toward sexual expression?
□ Positive □ Passive □ Repulsed □ Addictive □ Painful □ Fearful

Your current family composition:

Name	Relationship to You	Age	In Home (Y/N)

If applicable, how would you describe your relationship(s) with your children? _____

_____

_____

What stressors is your family currently facing? _____

_____

_____

What stressors have you overcome? _____

_____

What significant losses have you experienced? _____

_____

Who do you confide in?_____
Do you receive the support you need from the relationships you have? Y N
Why or why not? _____
Are you currently satisfied with your current friendships? Y N Please explain:

_____

_____

What fears or concerns do you have? _____

_____

What are your favorite things to do on your own? _____

_____

What are your favorite things to do with others? _____

_____

What are some things on your bucket list? _____

_____

Abuse/Victimization Issues

Have you ever felt like hurting yourself or someone else? If yes, please describe: _____

_____

Have you ever felt like killing yourself or someone else? If yes, please describe: _____

_____

Did you have a plan? If yes, please describe: _____
Did you have the means to carry out your plan? _____
Have you ever attempted suicide? If yes, when, and how? _____

Have you had any legal problems? If yes, please describe _____
_____
Have you been an abuser/been abused? Please describe briefly what happened and when, and who the abuser was:
Physically _____
Emotionally_____
Sexually_____
Verbally_____
Spiritually _____
Financially_____
Did you tell anyone? _____ What were the results of telling? _____
_____

Faith Background
Do you currently practice any religion or have spiritual beliefs? Y N If so, please describe:
_____
Do you believe in God? Y N Do you pray? Y N Do you read the Bible? Y N
Do you go to church? Y N If yes, how often? _____
Would you like your spirituality/faith to be a part of your counseling process? Y N If yes, please describe:
_____
_____
Please describe your family and personal devotions: _____
_____
Have you received Jesus Christ as your personal Lord and Savior? Y N N/A
If you were to die tonight, would you be certain you would go to heaven? Y N
Why did you answer this question the way you did? _____
_____
Were you raised in a religious/spiritual home? If yes, please describe: _____
_____
_____

Additional Information
Please include any other helpful information you would like your counselor to know about you or anything else that you would like to discuss: _____
_____
_____
_____
_____
_____
_____
_____