Soul Counseling, LLC

Client Intake Form Demographics

Name: _____ Date: _____

Address: _____

City: _____ State: _____Zip: _____ County: _____

It is customary Soul Counseling, LLC practice to mail a letter of termination at the end of treatment. If the above is not a safe or preferred mailing address for you to receive mail at, please provide an alternate mailing address here:

_____

Phone: (H)_____ (C) _____ (W) _____

Email: _____Method of contact: Phone or Email (circle one)

Age: _____ DOB: _____ Religious Affiliation: _____

Employer: _____ Occupation: _____

Marital Status: (circle one) Single Married (years married_____) Divorced Widowed

Children: Name Age

_____ _____

_____ _____

_____ _____

_____ _____

Referred by: _____

Previous Counseling Previous Counseling? Yes No Who and When? _____

_____

Release of information signed to talk with previous counselors? Yes No (not sure)

Medical/Mental Health Information

What, if any, medical health problems do you have? _____

386-209-8734 100 Court Street, SE Suite 105 Live Oak FL 32062 info@soul-counselingllc.com

Physician _____

Current Medications: _____

Are you on disability? No Please describe _____

Are you currently taking medication for a mental or emotional condition _____

Please list conditions and medications:

_____

Have you ever been hospitalized for a mental or emotional condition? _____

If so, please list where and
when:_____

Do you currently use any alcohol or drugs? No If yes, what is your substance of choice?

_____

Are you in treatment? (such as outpatient) or utilizing support groups (such as AA)? _____

If yes, please describe:

_____

What types of self-care practices have been helpful to you in the past when dealing with difficult situations? These may be things you learned from previous therapy or discovered on your own. Examples: journaling, exercising, workbooks, prayer, support groups.

_____

What are some of your hobbies/interests?

_____

Reasons for seeking counseling: In a few words, what do you think therapy is all about?

_____

How long do you think therapy should last?

_____

How long are you able to commit to therapy?

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What personal qualities do you think the ideal therapist should possess?

_____

Emergency contact information:

Name: _____

Relationship: _____

Phone: _____

Client Signature: _____

Date: _____

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