Intake Date
Provisional Dx

Soul Purpose Counseling & Consultation, PLLC
GENERAL INFORMATION FORM

NAME_____ BIRTHDATE_____

ADDRESS_____

E-MAIL_____ PHONE_____

SOCSEC #_____ EMPLOYER_____

PCP_____ [phone | fax]_____

IN CASE OF EMERGENCY

CONTACT [name] _____ *[relationship]* _____

[phone | e-mail | other] _____

TYPE OF THERAPY **(check all that apply)**

- ☐ Assessment
- ☐ Psychotherapy
- ☐ EMDR
- ☐ Other
- ☐ Adult
- ☐ Minor
- ☐ Individual
- ☐ Couples
- ☐ Group
- ☐ Family

PAYMENT | INSURANCE

***Please bring insurance card/s and photo ID to your first visit.**

Primary Insurance_____

Policy ID_____

Group ID_____

INTAKE SUMMARY

Physiological diagnoses | physical problems or concerns

_____

Mental health diagnoses | mental and emotional problems or concerns

_____

History of substance use | abuse

_____

Lifetime history of surgeries

_____

Medications | *Please list all active prescribed medications and dosages first; provide additional past medications/trials, if known.*

_____

PRESENTING PROBLEM
What is the reason for which you are seeking services?

COMMON SYMPTOMS OF TRAUMA | Early Attachment Injuries
(select all that apply)

- ☐ INTRUSIVE THOUGHTS
- ☐ NIGHTMARES
- ☐ FLASHBACKS *(VISUAL IMAGES OF A PAST EVENT)*
- ☐ MEMORY PROBLEMS/LOSS OF MEMORY
- ☐ POOR CONCENTRATION
- ☐ DISORIENTATION
- ☐ CONFUSION
- ☐ MOOD SWINGS
- ☐ AVOIDANCE *(OF PEOPLE/PLACES/THINGS)*
- ☐ SOCIAL ISOLATION/WITHDRAWAL
- ☐ LOSS OF INTEREST
- ☐ EASILY STARTLED
- ☐ FATIGUE/EXHAUSTION
- ☐ TACHYCARDIA *(RAPID HEARTBEAT)*
- ☐ EDGINESS
- ☐ INSOMNIA
- ☐ PSYCHOSOMATIC COMPLAINTS *(ACHES/PAINS)*
- ☐ EXTREME ALERTNESS/HYPERVIGILANCE
- ☐ OVERWHELMING FEAR
- ☐ OBSESSIVE/COMPULSIVE BEHAVIORS
- ☐ DETACHMENT *(FROM PEOPLE/EMOTIONS)*
- ☐ EMOTIONAL NUMBING
- ☐ DEPRESSION
- ☐ GUILT
- ☐ SHAME
- ☐ IRRITABILITY
- ☐ ANGER
- ☐ ANXIETY
- ☐ PANIC ATTACKS

OTHER ACTIVE SYMPTOMS (if not mentioned above)

FAMILY HISTORY | Provide a brief summary; include names, ages, and any other relevant information.

HOW WOULD YOU DESCRIBE YOUR CHILDHOOD?

PATIENT CONSENT AND PROVIDER DISCLOSURE

SIGNATURE _____

DATE _____

INITIAL here _____ confirming you have read **PROFESSIONAL DISCLOSURE STATEMENT**