

SoJourney Christian Counseling, LLC

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Confidential Client Information

Welcome to SoJourney Christian Counseling. To help me get to know you better, please answer all questions as completely as possible. Information given is strictly confidential and is beneficial for providing the best possible service to you as a client. Feel free to ask for assistance if needed. Your responses will be discussed in your initial interview.

BACKGROUND INFORMATION

Name: _____ Today's Date: _____

Home Address: _____ (receive mail here? Yes/No)

City: _____ State: _____ Zip Code: _____

Home Phone: _____ (May call: Yes/No) (May leave a message: Yes/No)

Work Phone: _____ (May call: Yes/No) (May leave a message: Yes/No)

Cell Phone: _____ (May call: Yes/No) (May leave a message: Yes/No)

Email Address: _____ (May email: Yes/No)

Would you like emails about upcoming events or other information from New Day? Yes/No

Date of Birth: _____ Age: _____ Gender: Male Female

Marital Status: Married Never married Engaged Separated Divorced Widowed

Number of Marriages & Length of Each: _____

Are you currently involved in a custody dispute? Yes No

Are you currently involved in a legal dispute? Yes No

Religious Affiliation as a Child: _____ As an Adult: _____

Occupation: _____ Education: _____

Name of Person(s) to contact in case of an emergency:

1. _____ Phone: _____

2. _____ Phone: _____

Briefly describe your reason for seeking counseling: _____

How did you hear about SoJourney Christian Counseling? _____

Family of Origin (parents/guardians, siblings)

Name	Age	Relationship

Immediate Family Members (spouse, children)

Name	Age	Relationship

Does anyone in your immediate family or family of origin suffer from alcoholism, an eating disorder, depression or anything that might be considered a mental disorder? Yes No If yes, please explain: _____

MEDICAL INFORMATION

Primary Care Physician: Name: _____

Address: _____

Phone: _____

How would you rate your current physical health: Excellent Good Fair Poor

Are you currently experiencing any physical problems (e.g. headaches, body aches):

Yes No

If yes, please explain:

List medications you are currently taking:

Medication	Dosage and times per day

Current illnesses or disabilities:

Please list any learning disabilities:

Please list hospitalizations for medical reasons:

Date/Hospital and City	Reason

Number of pregnancies: _____ Number of miscarriages: _____ Number of abortions: _____

MENTAL HEALTH INFORMATION

Have you ever seen a mental health professional (psychiatrist, psychologist, or counselor)? Yes No

If so, do you feel it would be helpful for me to speak with that person? Yes No

Previous Mental Health Professional (name or agency): _____

Phone: _____ Dates of Service: from ___/___/___ to ___/___/___

Have you ever been hospitalized for mental health concerns? Yes No If yes, please explain briefly (include hospital, doctor's name and dates):

Has any family member ever:

Attempted Suicide Committed Suicide Attempted Homicide Committed Homicide

If yes, briefly explain:

Have you ever:

- Had suicidal thoughts Attempted Suicide Attempted Homicide Committed Homicide

If yes, briefly explain: _____

History of physical/sexual abuse? If yes, briefly explain: _____

CURRENT CONCERNS

- | | | |
|---|---|---|
| <input type="checkbox"/> Abuse (physical, emotional, sexual) | <input type="checkbox"/> Feel panicky | <input type="checkbox"/> Self-control issues |
| <input type="checkbox"/> Abuse of non-prescription drugs | <input type="checkbox"/> Feel numb or lacking emotion | <input type="checkbox"/> Sexual identity concerns |
| <input type="checkbox"/> Adjustment to life changes (move, job) | <input type="checkbox"/> Feel "on top of the world" | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Feel ashamed | <input type="checkbox"/> Sleeping all the time |
| <input type="checkbox"/> Anxiety (nervous, fearful, worried) | <input type="checkbox"/> Feel distant from God | <input type="checkbox"/> Spouse problems |
| <input type="checkbox"/> Behavior problems | <input type="checkbox"/> Feel fat | <input type="checkbox"/> Suicidal urges/thoughts |
| <input type="checkbox"/> Being a parent | <input type="checkbox"/> Feel guilty | <input type="checkbox"/> Suspicious of other people |
| <input type="checkbox"/> Binging/Vomiting/Laxative use | <input type="checkbox"/> Feel inferior | <input type="checkbox"/> Take sedatives |
| <input type="checkbox"/> Blackouts or temporary loss of memory | <input type="checkbox"/> Financial problems | <input type="checkbox"/> Tense feelings |
| <input type="checkbox"/> Bowel disturbances | <input type="checkbox"/> Health concerns | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Career choices | <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Unable to relax |
| <input type="checkbox"/> Children having problems | <input type="checkbox"/> Inability to control thoughts | <input type="checkbox"/> Unable to sit still |
| <input type="checkbox"/> Compulsive behaviors | <input type="checkbox"/> Insomnia (unable to sleep) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Crying spells | <input type="checkbox"/> Lack of motivation | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Depressed (sadness) | <input type="checkbox"/> Learning/academic difficulties | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Difficulty having fun | <input type="checkbox"/> Legal matters | |
| <input type="checkbox"/> Difficulty making friends | <input type="checkbox"/> Lose time | |
| <input type="checkbox"/> Disturbing memories | <input type="checkbox"/> Loss of interest in sex | |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Memory problems | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nightmares | |
| <input type="checkbox"/> Drugs | <input type="checkbox"/> No appetite/excessive appetite | |
| <input type="checkbox"/> Easily distracted | <input type="checkbox"/> Non-family relationship problems | |
| <input type="checkbox"/> Education | <input type="checkbox"/> Palpitations | |
| <input type="checkbox"/> Excessive boredom | <input type="checkbox"/> Parent/child relationship problems | |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Poor home environment | |
| <input type="checkbox"/> Family or step-family relationships | <input type="checkbox"/> Problems with alcohol | |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Problems with prescription drugs | |
| <input type="checkbox"/> Feel lonely | <input type="checkbox"/> Religious/Spiritual concerns | |