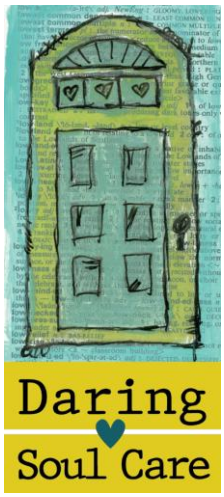

7890 St. Andrews Cir
Orlando, FL 32835
(407) 342-3559
debbie@
daringsoulcare.com

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CLIENT INFORMATION

Contact and Household Information

I am here to see: _____ Date: _____

Client Name: _____

Age: _____ D.O.B: _____ Last 4 digits of SSN.: _____

Home Address: _____

_____

Primary Phone: _____ Secondary Phone:_____

Preferred email address: _____

Permanent Address: Same as above ❒ Yes ❒ No If no, please provide:

_____

May we leave a message for you at: Primary Number: ❒ Yes ❒ No

Secondary Number: ❒ Yes ❒ No

May we contact you via text to discuss scheduling/other issues? ❒ Yes ❒ No

May we contact you via email to discuss scheduling/other issues? ❒ Yes ❒ No

How did you hear about our practice? _____

If applicable, may we thank your referral source? ❒ Yes ❒ No

Emergency Contact: _____

Phone Number:_____

Occupation: _____

Work Status: Full-time ❒ Part-time ❒ _____ avg. hours/week

Employer/School:_____

Average Annual Gross Household Income: _____

Marital status:
Married ❒ Remarried ❒ Single ❒ Widow(er) ❒
Divorced ❒ Separated ❒ Other ❒ _____

If applicable, Spouse's Name: _____

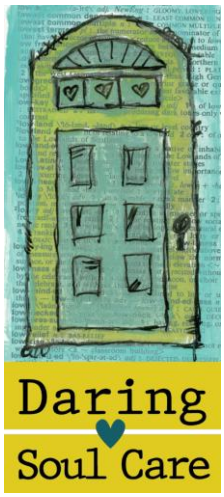
Do you have children? ❒ Yes ❒ No

If yes, names and ages _____

_____

Who lives in your home? _____

Revised: September 2, 2016



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CLIENT INFORMATION

History, Current Status & Counseling Goals

Have you ever seen a mental health professional (psychiatrist, psychologist, or counselor)? ❒ Yes ❒ No If yes, when? _____

Please briefly list the reasons: _____

_____

_____

Are you currently taking any medications? ❒ Yes ❒ No If yes, explain:

_____

_____

_____

What brings you to counseling today? What goals would you like to accomplish?

_____

_____

_____

_____

What is your current level of distress? Please mark an "X" on the scale below;
(1 = very little distress; 10 = extreme distress):

_____

1 2 3 4 5 6 7 8 9 10

Are you currently having suicidal thoughts? ❒ Yes ❒ No If yes, briefly describe:

_____

_____

_____

Have you experienced them or attempted suicide in the past? ❒ Yes ❒ No
If yes, briefly describe:

_____

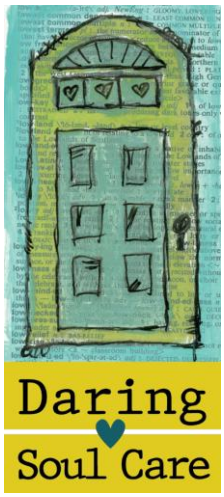
_____

_____

Personal Beliefs and Support System

What words would you use to describe yourself? _____

_____



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CLIENT INFORMATION

How important is spirituality/faith to your life? Please mark an "X" on the scale below:
(1 = not important at all; 10 = extremely important):

_____

1 2 3 4 5 6 7 8 9 10

If God were to describe you, what do you imagine that God would say?

_____

Briefly describe the spiritual/religious environment of your home growing up:

_____

_____

Complete this thought: "God is _____

_____."

Do you regularly attend a place of worship? ❒ Yes ❒ No If yes, where?

_____

Do you have a personal support system? ❒ Yes ❒ No If yes, please describe:

_____

_____

Have you completed any of the following inventories or assessments?
(Check all that apply; if you know the results, please list them.)

- ❒ Myers Briggs Type Indicator Results: _____
- ❒ Enneagram Results: _____
- ❒ StrengthsFinder 2.0 Results (top 5): _____

  _____
- ❒ Spiritual gifts inventories: Results: _____

  _____

Terms of Service

I have read, understood, and agree to comply with the Policies and Procedures of Daring Soul Care. I attest that the information provided here is accurate as of this date. I will promptly notify my Daring Soul Care therapist of any changes to this information.

Signature: _____ Date: _____

Printed Name: _____