Soul Care
Healing & Equipping the Church Community
www.MySoulCare.com

Bridgeway
CHRISTIAN CHURCH

NEW CLIENT INTAKE FORM – MINOR

Welcome to Soul Care, the professional counseling ministry at Bridgeway Christian Church.
We believe it is courageous to take the first step in seeking support with life's issues.
We truly look forward to walking with you.

Today's Date: _____

Directions

Please complete this New Client Intake Form for each minor counseling participant. Please note that if the counseling participant is an adult receiving services, there is a separate intake form to be completed.

We strongly encourage each client to take the time to thoroughly complete this form. We have found that doing so will greatly enrich the start of your experience; assisting your counselor in tailoring the best treatment possible for you.

Once complete, please submit the form(s) in one of the following three ways:

1) Scan/Email the form(s) to support@mysoulcare.com;
2) Drop the completed form(s) off, in a sealed envelope, in the confidential lockbox located in the Soul Care waiting room either before/after services or Monday through Friday from 9:00am to 4:00pm. Please follow signs from the main church entrance.
3) Mail the form in a sealed envelope, addressed to Soul Care, at 8150 Industrial Avenue, Building A, Roseville, California 95678;

All the above options are confidentially monitored by Soul Care staff, Monday through Friday. Once received, you will be contacted within 24 business hours, via email, with confirmation and an update on the current referral-to-counselor process along with additional paperwork to bring to your first appointment.

General Information

_____ _____ _____
Minor Client Name | Date of Birth | Age

_____ _____
Name of Person filling out form (if different) | Relationship to Client

_____ _____ _____
Minor Client Address | City | Zip

_____ _____
Minor Cell Phone (if applicable) | Minor Email Address (if applicable)

_____ _____
Minor School | Grade

_____ _____ _____ _____
Parent / Guardian Name | Parent Cell Phone | Parent Work Phone | Parent Email Address (*Required)

_____ _____ _____ _____
Parent / Guardian Name | Parent Cell Phone | Parent Work Phone | Parent Email Address (*Required)

_____ _____
Emergency Contact (If parents/guardians are unavailable) | Relationship to Minor Client

_____ _____ _____
Address | Phone | Email Address

Counseling Information

How did you hear about Soul Care? _____

Have you (minor) been seen by a Soul Care counselor before? Yes ☐ No ☐ Approx. Dates: _____

Have you (minor) had previous counseling or psychotherapy outside of Soul Care? Yes ☐ No ☐ Approx. Dates: _____

What were the reasons for previously seeking counseling or psychotherapy? _____

_____

Did you (minor) have a positive experience either within or outside Soul Care? Yes ☐ No ☐ I Don't Know ☐

Please briefly describe what brings you to therapy: _____

_____

Please describe what you hope to achieve in therapy: _____

_____

Services desired: Individual therapy ☐ Marital/Couples therapy ☐ Family therapy ☐

How do you prefer to be contacted? Please check all that apply. Phone Call ☐ Text * ☐ Email * ☐

* Most counselors are willing to maintain contact with you via text, email, or other electronic means. Although we cannot be certain that this information will not be intercepted, we will do our part to protect your confidentiality.

____ Please initial here indicating you understand the risk of communicating by electronic means, still wish to do so, and consent to electronic communication with Soul Care at Bridgeway Church.

When we contact you, may we identify ourselves as counselors from Soul Care or Bridgeway? Yes ☐ No ☐

May we leave a voicemail message if contacting you via phone call? Yes ☐ No ☐

Please provide at least two days and ranges of times. We will make every effort to meet your availability, however, this is not a guarantee for appointment days and/or times.

Days:	Mondays	Tuesdays	Wednesdays	Thursdays	Fridays	Saturdays	Sundays
Times:							

Financial Information

Soul Care strives to offer quality counseling at an affordable fee. Session fees are based on a sliding scale, determined by monthly gross income and ability to pay.

Monthly gross income includes all forms of household income such as pension, disability, unemployment, stipends, commission, salary, etc.

Please check one of the following:

☐ I will be participating in individual, couple, child, or family counseling.

My monthly gross household income is: _____

☐ I will be participating in a counseling group.

Name of Group: _____

Group session fee: _____

Personal History Inventory

Thank you in advance for openly providing the details below for minor counseling participant. All information will remain confidential as stated in the Informed Consent Form provided to you by Soul Care prior to the start of therapy. This assessment provides your counselor with additional information to clinically support you.

Marital Status of Parents/Guardians:

- ☐ Single, never married
- ☐ Live-in partner (for ___ years)
- ☐ Engaged (for ___ months)
- ☐ Married (for ___ years)
- ☐ Widow (for ___ years)
- ☐ Separated (for ___ years)
- ☐ Divorced (for ___ years)
- ☐ Prior marriages (number ___)

Social Support System of Minor:

- ☐ Supportive network
- ☐ Involved in church / community
- ☐ Few friends
- ☐ Distant from family
- ☐ No friends
- ☐ Other: _____

Military History of Parents/Guardians:

- ☐ Never personally in military
- ☐ Military family growing up
- ☐ Currently in military
- ☐ Served in military – honorably discharged
- ☐ Served in military – dishonorably discharged
- ☐ Served in military – retired
- ☐ Other: _____

Substance Use History of Minor:

- ☐ No current use
- ☐ Active Use
  (Frequency: Daily ☐ Weekly ☐ Monthly ☐)
- ☐ No history of abuse
- ☐ Active abuse
- ☐ Past abuse

Treatment History of Minor:

- ☐ No treatment history
- ☐ Outpatient (Last Date: _____)
- ☐ Inpatient (Last Date: _____)
- ☐ 12-Step Program (Last Date: _____)
- ☐ Stopped Independently (Date: _____)
- ☐ Other: _____

Employment of Minor:

- ☐ Unemployed
- ☐ Student, part time
- ☐ Student, full time
- ☐ Employed, satisfied
- ☐ Employed, dissatisfied
- ☐ Coworker conflicts
- ☐ Supervisor conflicts
- ☐ Other: _____

Financial Situation of Household:

- ☐ No current financial problems
- ☐ Poverty or below-poverty income
- ☐ Large indebtedness
- ☐ Impulsive spending
- ☐ Relationship conflicts over finances
- ☐ Other: _____

Legal History of Minor:

- ☐ No legal issues
- ☐ Past/Current parole/probation
- ☐ Arrest(s) – Not substance-related
- ☐ Arrest(s) – Substance-related
- ☐ Therapy/Counseling is court-ordered
- ☐ Past Jail/Prison time (___ # times)
- ☐ Other: _____

Current Use Substance(s) of Minor:

- ☐ Caffeine
- ☐ Alcohol
- ☐ Nicotine
- ☐ Prescription
- ☐ Other: _____

Family Alcohol/Drug Abuse History:

- ☐ Parent(s) / Guardian(s)
- ☐ Grandparent(s)
- ☐ Sibling(s)
- ☐ Uncle(s) / Aunt(s)
- ☐ Spouse / Significant Other
- ☐ Children
- ☐ Other: _____

Current Household Members:

Please list household members other than minor counseling participant and state what minor's relation is to the other members. (i.e., parent, biological sibling, adopted sibling, foster child, step-sibling, spouse's child, friend, etc.)

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Spiritual Information

How would you (minor) describe your spiritual/religious upbringing? _____

_____

Do you (minor) presently identify with a certain affiliation/denomination? Yes ☐ No ☐ I Don't Know ☐

If so, which one: _____

Do you (minor) currently attend a church? Yes ☐ No ☐ Sometimes ☐

If so, where: _____

Medical/Psychiatric History

Name of Minor's Doctor or Psychiatrist: _____

Medical Group: _____ Phone Number: _____

Are you (minor) presently being treated for any health problems? Yes ☐ No ☐ If yes, please briefly share the health problem(s). _____

Date of last complete physical exam: _____

Please list all current medications, including dosage, frequency, and reason. _____

_____

Previous psychiatric, emotional, or substance use hospitalization and/or inpatient treatment? Yes ☐ No ☐

If yes, please indicate the most recent date, reason, location, and number of occasions. _____

_____

Family of Origin Information

Minor Place of Birth: _____Ethnicity: _____

Did you (minor) move around a lot before the age of 18? Yes ☐ No ☐

Childhood Family Experience:

- ☐ Outstanding home environment
- ☐ Normal home environment
- ☐ Chaotic home environment
- ☐ Witnessed physical/verbal/sexual abuse toward others
- ☐ Experienced physical/verbal/sexual abuse from others

If raised by someone other than biological parents, whom? _____
Any other details of your childhood and/or family of origin that you believe is important to know at the start of therapy?
_____
_____

Target Symptoms

Please indicate all symptoms the minor client has experienced by marking the level that best describes their severity. Check one level for each applicable symptom, and indicate how long the symptom has been present.

Depressed Mood	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Fatigue/Low energy	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Hopelessness/Helplessness	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Elevated Mood	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Body Complaints	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Suicidal Ideas	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Weight Gain/Loss	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Anxiety	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Lack of Concentration	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Sleep Disturbance	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Panic	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Phobias	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Obsessions/Compulsions	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Impulse Control Issue (Temper)	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Violence, Anti-social Behavior	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Unusual Energy	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Racing Thoughts	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Disorganized Thinking	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Bizarre Ideation/Impulses	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Homicidal Impulses	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Binging/Purging	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Mood Swings	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Irritability	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Delusions	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Hallucinations	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Conduct Problems	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Social Isolation	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Worthlessness	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Hyperactivity	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Dissociative States	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Aggressive Behavior	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:
Alcohol/Substance Over Use	None ☐	Mild ☐	Moderate ☐	Severe ☐	Duration:

Thank you being open about these details. All information will remain confidential.
Please follow the directions on Page 1 for submitting this form. As soon as it is received, we will be in contact within 24 hours, via email, with confirmation and a quick update on the current referral-to-counselor process.
Again, welcome to Soul Care. We look forward to walking with you.