BRIAN HOOPER, M.DIV., PSY.D.
SOUL AND PSYCHE
LICENSED PSYCHOTHERAPIST LCPT #54

Confidential
Intake Form

Brian Hooper, M.Div., Psy.D.
Soul and Psyche
Licensed Psychotherapist LCPT #54

4525 Harding Road, Suite
207 Nashville, TN 37205
(615) 485-5923

Intake Form

Today's Date:______________

Client's Name: ____

Age:________ Birth Date:__________________

Address:____

(Street) (City) (State) (ZIP)

*Permission is granted to send letters to Physical Address (____Yes or ___No)

Home # ________________ Cell # ________________ Work# ________________

*Permission is granted to leave voice messages (____Yes or ____No)

*Permission is granted to send text messages (____Yes or _____No)

At which phone number may a message be left? ____

Email Address: ____

*Permission is granted to send messages to email (___Yes or ____No)

Personal and Family Information

Self-Perception of Sexual Orientation: Circle the (*) on the scale below that best represents where you see yourself to be on a scale from Heterosexual (Straight) to Homosexual (Gay).

• • • • • • • •

Straight -- Gay

Other:____

Marital Status:

- ___Single
- __Engaged How long? ____
- __Married/Partnered How long? ___ Times married/partnered?______
- __Divorced/Separated How long? ____

Education: ____________________________ Occupation: ______________________________

Spouse or Significant Other's Name: ____________________ Age:__________

List the name, birth date, sex, relationship of all children, and whether they live with you.

Name	Present Age	Sex	Relationship	At Home?

If necessary, continue on back of page or attach an additional sheet.)

Religious belief/spiritual practice:____

Are either parents or grandparents diagnosed as alcoholics/heavy drinkers or recreational drug users? Yes____ No____ If so, who?____

Prior Counseling

Have you had any prior counseling?

Yes____ No______ If yes. when?________________ Where? __________________________

With whom? ____

Why? ____

From: ________________ to ________________

What was most beneficial about your counseling experience? ________________________________

____

Are you or another family member, currently seeing a psychiatrist or another counselor?

Yes____ No______

If so, who is in therapy? ____

Name of counselor ____

For what purpose? ____

Presenting Concerns

State the problem that brings you for counseling:____

____

What have you done about this problem? ____

____

What is your most difficult relationship right now? ____

What is your most difficult emotion right now? ____

Common Problems/Symptom Checklist

Fill in : 0 = none, 1= mild, 2 = moderate, 3 = severe

___ marriage/partnership	___ disabled	___ loneliness
___ premarital	___ work/career	___ mood swings
___ singleness	___ school/learning	___ God/faith
___ sexual issues	___ money/budgeting	___ church/ministry
___ family	___ aging/dependency	___ past hurts
___ children	___ weight control	___ codependency
___ parents	___ alcohol/drugs	___ intimacy
___ in-laws	___ other addictions	___ communication
___ divorce/separation	___ grief/loss	___ self esteem
___ sexual orientation	___ depression	___ stress management
___ gender identity	___ fear/anxiety	___ anger control

Crisis Information

Person to contact if you were involved in an emergency (name, relationship, phone, address):

____

____

Any current or suicidal thoughts, feelings or actions?

___ Yes ___No If yes. explain: ______________________________

Any current homicidal or assaultive thoughts, feelings. or anger-control problems?

___ Yes ___No If yes, explain:______________________________

Any past problems, hospitalizations. or jailings for suicidal or assaultive behavior?

___Yes ___ No If yes. describe:______________________________

____

____

Any threats of significant loss or harm (illness, divorce, custody, job loss, etc.)?

____ Yes ___ No If yes. describe:______________________________

Medical Information

Doctor's name, address, and phone:

____

____

Are you presently taking any medication?
____Yes___No If so, please list below :

Name of Medication	Dose	For What Purpose
I. ______________	______	______________
2. ______________	______	______________
3. ______________	______	______________
4. ______________	______	______________
5. ______________	______	______________
6. ______________	______	______________

(If necessary, continue on back of page or attach an additional sheet.)

Have you recently ceased taking any medication ? ____ Yes ____No If yes, please list below:

Name of Medication	Dose	Reason for Stopping

(if necessary, continue on back of page or attach an additional sheet)

Do you currently drink alcohol? ___ Yes ___No If so, how much and how often?

Do you use/have you used any illegal substances? ___Yes___ No If so, what, when and how much?

Any problems with the following:

_ eating _ sleeping
_ chronic pain _ recent weight changes

Describe any answers checked in previous question :

Any other medical problems?

Have you or a family member ever been hospitalized for mental or emotional illness?

___Yes___ No If yes. please note approximate date(s), place(s), and reason(s):

Please describe your diet:

Do you take any dietary supplements? ___Yes ___ No If yes, please list them :

Please describe your sleep patterns, including amount and times:

Are you willing to make whatever lifestyle changes (nutrition, exercise, sleep, alcohol or drug use) necessary to reduce your discomfort/suffering and maximize your wellbeing, wholeness, and peace?
____Yes ____No If you feel a need to further explain, please do below:

Do you wish to receive information about prescription medication/environment/exercise/nutrition options that might either contribute to your distress or support your wellbeing? ____ Yes ____ No

Who referred you to me? (name, relationship, and phone num ber)

If a professional referred you to me, may I acknowledge your contact? (If yes, I will only acknowledge your contact; any other information will require your express written permission.)___Yes ___No

Additional Notes:

I have answered to the very best of my ability and certify that my answers are accurate to the best of my knowledge. If the means of communication which I have authorized in this document change, I will notify Dr. Hooper in writing.

Signed ____ Date ____ /_____ /_____

Print Name____ Mo Day Year

THANK YOU for taking the time to fill out this information form. I will review this with you in the first session and use it to best assist you in your counseling work. I will maintain your strict confidence regarding this information, subject to the exceptions noted in your "Pastoral Counseling Agreement". Be sure you review and sign the elements of the agreement.