Spiritual Care Support Ministries
Client Intake Form

General

Client Name | Today's Date

Cell Phone | Home Phone

Email | Date of Birth | Marital Status

Street Address

City | State | Zip code

Spouse's name

Children's names and ages

Parents' names if client is a minor

Where and with whom does minor live?

Background

Profession:	Military Service:
Hobbies:	Cultural/ethnic concerns:
Religious preference:	Synagogue/Church/Temple:
Clergy name:	Permission to contact clergy? ☐ Yes ☐ No
History of anxiety? ☐ Yes ☐ No	History of depression? ☐ Yes ☐ No
Are you chronically ill? ☐ Yes ☐ No	Are you under a doctor's care? ☐ Yes ☐ No
Other medical concerns:	

History of Losses

Name/Relationship	When	How
Pet Loss? ☐ Yes ☐ No Names:		

Support

How can SCSM best support you? Please list any past or current traumas, or other issues you'd like to discuss (for example, PTSD, childhood abuse, relationship issues, etc.)

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Do you have support? ☐ Yes ☐ No If yes, please list (for example, family member, friend, doctor, church community, etc.) ____

____ ___________________________
Signature Date

____
Print name

If client is a minor, please print minor's name: ____