soulCare
a biblical counseling ministry of Calvary Baptist Church

SoulCare Counseling Request

(If seeking counseling for a child or teen, please fill out the yellow form marked "Under 18")

Date: _____

Welcome to SoulCare! Please complete with as much detail as you feel comfortable sharing. Be assured that your information is seen only by the counselor and appropriate SoulCare leadership.

PERSONAL INFORMATION

Name: _____ Age: _____ Date of Birth: _____ Sex: _____

Mailing Address: _____ City _____State: ___ Zip: _____

Email Address: _____ Phone: _____

Preferred Method of Contact (Consider Confidentiality): _____

Emergency Contact Name: _____

Relationship: _____ Phone: _____

Who referred you or how did you hear about SoulCare? _____

(Website, Church Bulletin, Pastor Friend, Redemption Group, Other) *Please name person above.* _____

Your Occupation: _____ Employer: _____

FAMILY INFORMATION

Marital Status: _____ Wedding Date of Current Marriage (if applicable): ___/___/___

Spouse's Name (if applicable): _____ Phone: _____

Have you ever been separated? ☐ Yes ☐ No Ever filed for divorce? ☐ Yes ☐ No If so, when? _____

Have you ever had any prior marriages? _____

Number of Children/Ages: _____

Describe any significant event/information about your family that would be beneficial for counseling: _____

_____

_____

_____

REASON FOR SEEKING HELP

What concerns have led you to pursue counseling? _____

What areas of your life are being most affected by this issue? (***Check all that apply):***

☐ Home ☐ Work ☐ Marriage ☐ Other Relationships ☐ Relationship with God

When did the present concern begin to be a problem for you? _____

Were there any significant events occurring in your life / family when this issue began? _____

_____

_____

How have you already tried to resolve the issue? _____

Have you ever gone to a counselor? ☐ Yes ☐ No If yes, was the counseling Christian or secular ***(circle one)***?

How do you feel about the results of your previous counseling? _____

What do you hope to gain from SoulCare? _____

Please rate the severity of your present concerns on the following scale (***Check one***):

◯ Mild ◯ Moderate ◯ Severe ◯ Totally incapacitating

What do you desire most in life? _____

What do you fear most in life? _____

MEDICAL HEALTH

Rate your health **(*Check one*):**

◯ Excellent ◯ Good ◯ Average/Fair ◯ Poor ◯ Other

Have there been any significant weight changes in the past year? ◯ Yes ◯ No

List any major present or past illnesses, injuries or disabilities: _____

_____

Are you presently taking any psychiatric medication? ◯ Yes ◯ No

If so, for what purpose? _____

Have you been previously hospitalized or seen a doctor for psychiatric reasons? ◯ Yes ◯ No

RELATIONSHIP WITH GOD AND CHURCH

Do you attend Calvary? ◯ Yes (once or twice a month) ◯ Yes (more than twice a month) ◯ No

Are you a member of Calvary? ◯ Yes ◯ No ◯ No, but I am interested in becoming a member

What ministries are you currently being blessed by? _____

Are you serving in any ministry at Calvary? ◯ Yes ◯ No If yes, describe: _____

_____

Are you involved in another church? ◯ Yes ◯ No

Are you involved in a Community Group? ◯ Yes ◯ No

Are you trusting in Jesus and His death and resurrection for your salvation? ◯ Yes ◯ No ◯ Not sure

Please describe how your relationship with Jesus Christ began and where it is now: _____

_____

_____

_____

Describe your sense of God's involvement in your daily life: _____

_____

_____

_____

EMOTIONAL ASSESSMENT

Have you experienced abuse in your past? ◯ Yes ◯ No Are you experiencing abuse now? ◯ Yes ◯ No

Do you ever feel suicidal? ◯ No ◯ Yes (sometimes) ◯ Yes (Past attempts) ◯ Yes (I have an active plan)

Do you feel depressed? ◯ No ◯ Mildly ◯ Moderately ◯ Severely

Do you feel anxious? ◯ No ◯ Mildly ◯ Moderately ◯ Severely

Do you feel overwhelmed? ◯ No ◯ Mildly ◯ Moderately ◯ Severely

Please provide additional details, if any, regarding your level of feeling suicidal, depressed, anxious, and/or overwhelmed: _____

_____

_____

_____

Do you use drugs? ◯ Yes ◯ No Do you use alcohol? ◯ Yes ◯ No

If yes, drug/alcohol of choice _____

Last use: _____ Frequency: _____

Please list any addiction-like struggles: _____

(Examples: drugs, alcohol, food, exercise, sex, pornography, work, video games/cyber, shopping, television, etc.)

Please check how often the following thoughts or experiences occur to you?

1.	Life is hopeless.	◯ Never	◯ Rarely	◯ Sometimes	◯ Frequently
2.	I am lonely.	◯ Never	◯ Rarely	◯ Sometimes	◯ Frequently
3.	No one cares about me.	◯ Never	◯ Rarely	◯ Sometimes	◯ Frequently
4.	I am a failure.	◯ Never	◯ Rarely	◯ Sometimes	◯ Frequently
5.	Most people do not like me.	◯ Never	◯ Rarely	◯ Sometimes	◯ Frequently
6.	I want to die.	◯ Never	◯ Rarely	◯ Sometimes	◯ Frequently
7.	I want to hurt someone.	◯ Never	◯ Rarely	◯ Sometimes	◯ Frequently
8.	I am stupid.	◯ Never	◯ Rarely	◯ Sometimes	◯ Frequently
9.	I am going crazy.	◯ Never	◯ Rarely	◯ Sometimes	◯ Frequently
10.	I cannot concentrate.	◯ Never	◯ Rarely	◯ Sometimes	◯ Frequently
11.	I am depressed.	◯ Never	◯ Rarely	◯ Sometimes	◯ Frequently
12.	God is disappointed in me.	◯ Never	◯ Rarely	◯ Sometimes	◯ Frequently
13.	I cannot be forgiven.	◯ Never	◯ Rarely	◯ Sometimes	◯ Frequently
14.	Why am I so different?	◯ Never	◯ Rarely	◯ Sometimes	◯ Frequently
15.	I cannot do anything right.	◯ Never	◯ Rarely	◯ Sometimes	◯ Frequently
16.	People hear my thoughts.	◯ Never	◯ Rarely	◯ Sometimes	◯ Frequently
17.	I have emotional numbness.	◯ Never	◯ Rarely	◯ Sometimes	◯ Frequently
18.	I am out of control.	◯ Never	◯ Rarely	◯ Sometimes	◯ Frequently

Please comment about each of the above thoughts that occurred frequently or are a concern to you:

_____

_____

_____

Please indicate which of the following areas currently are problems for you. ***(Check all that apply)*:**

- ☐ Angry feelings/outbursts
- ☐ Concern about finances
- ☐ Excessive fear of specific places/objects
- ☐ Difficulty making friends
- ☐ Feeling as if you would be better off dead
- ☐ Feeling that people are out to get you
- ☐ Delusions
- ☐ Crying episodes
- ☐ Loss of interest in usual activities
- ☐ Lack of motivation
- ☐ Inability to control thoughts
- ☐ Hearing voices
- ☐ Lack of energy
- ☐ Feeling worthless
- ☐ Issues with transgender identity
- ☐ Difficulty making decisions
- ☐ Loss of interest in sexual relationships
- ☐ Feeling sexually attracted to same sex
- ☐ Concerns about physical health
- ☐ Blackouts or temporary loss of memory
- ☐ Loss of appetite/increased appetite
- ☐ Issues with food and/or weight
- ☐ Feeling distant from God
- ☐ Nightmares Obsessions/compulsions with specific activities
- ☐ Feeling trapped in rooms/buildings
- ☐ Visual hallucinations
- ☐ Excessive feelings of guilt/shame
- ☐ Feeling manipulated or controlled by others
- ☐ Insomnia (no sleep) or hypersomnia (sleep all the time)
- ☐ Other: _____

SETTING UP AN APPOINTMENT

Please check *ALL* possible times you are available to meet for counseling.

(Sessions are 45 minutes long)

	9 am	10 am	11 am	Noon	1 pm	2 pm	3 pm	4 pm	5 pm	6 pm	7 pm	8 pm
Mondays	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tuesdays	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Wednesdays	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thursdays	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Fridays	☐	☐	☐	☐	☐	☐	☐	☐				

ONCE YOU HAVE COMPLETED THIS FORM, PLEASE…

1. Drop the form off at the church office, or in the SoulCare mailbox next to the church office window,
   OR
2. Submit online using the online request form
3. ***OR***
4. Email it to Pastor Paul at pwilson@calvarybaptistpa.org
   OR
5. Mail it to:
   Pastor Paul Wilson
   Calvary Baptist Church
   5300 Green Pond Rd.
   Easton PA 18045

Pastor Paul and/or a counselor will contact you as soon as they are able, to discuss when counseling can begin.
If you have any questions, please feel free to call the church office to speak with Pastor Paul 610.365.5300.