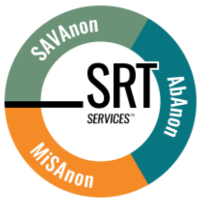


SRT SERVICES
CLIENT INTAKE FORM

First Name: **Mi:** **Last Name:**

Date of Birth: **Address:**

City: **State:** **Zip:**

Phone:

May we contact you by phone? Yes No **Is it ok to leave a message?** Yes No

May we text appointment reminders? Yes No

Have you ever been to this TRC before?

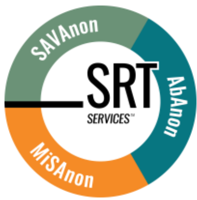
How did you hear about us?

Reason for coming today?

___Sexual Abuse or Sexual Assault Trauma
___Past Abortion Trauma
___Miscarriage/Stillbirth Trauma
___Pregnancy Services
___STD Services

Signature **Date**

For TRC use only:
If no to any of the contact questions above, how are we to contact client? ________________________________
Staff Member: **Date:**



SRT SERVICES
SEXUAL ABUSE OR ASSAULT INFORMATION

NAME: **DATE OF BIRTH:** **TODAY'S DATE:**

TERMS:

Sexual Abuse
Nonconsensual or consensual sexual activity of an adult with a child or minor (under legal age of consent).
Sexual Assault:
Nonconsensual sexual activity. Forcing a victim to perform sexual acts.

We understand that sharing information about the past is not easy and can be very unpleasant. Please do not feel any pressure to do so. However, in order to know how to best support and care for you, it would be helpful to know more about your history.

Have you experienced sexual abuse/assault? _______Yes _______No
If you feel comfortable, please check any of the sexual abuse/assault traumas you have experienced.

TYPES OF SEXUAL ABUSE/ASSAULT

___Exhibitionism
___Voyeurism
___Fondling
___Child Sex Abuse
___Attempted Rape
___Rape (Incest)
___Sexual Assault
___Satanic Ritual Abuse
___Sex Trafficking/Exploitation

AFTER SEXUAL ASSAULT OR ABUSE

Check all that apply to you

	EMOTIONALLY	
	Sadness	
	Anger	
	Fear	
	Guilt	
	Helplessness	
	Depression	
	PHYSICALLY OR BEHAVIORALLY	

	Changes In Sleep	
	Changes in Appetite	
	Emptiness	Felt Physically in The Chest, Stomach, Or Elsewhere in The Body
	Restlessness	Inability To Sit Still or Concentrate
	Lethargy	Exhaustion Or Loss of Energy
	Tears	Grief Bursts That Can Occur at Unexpected Times
	Distracted Behaviors	Constant Work or Relocation; Self Destructive or Addictive Behaviors
	Reminiscing	Telling Or Retelling Stories About the Abuse or Assault
	COGNITIVELY	
	Disbelief	An Inability to Believe It Happened
	Forgetfulness	Not Finishing What Is Started; Absentmindedness
	Poor Focus	Difficulty Concentrating on Tasks or Lack of Motivation
	Questioning	Asking Or Wondering Why
	SPIRITUALLY	
	Searching For Meaning	Wondering About the Purpose in Life
	Altering Personal Beliefs	Values Or Beliefs May Be Questioned or Discarded

Victims of sexual violence are usually reluctant to tell anyone about what they experienced. Read through the following list.

Can you identify with any of these statements?
If you feel comfortable, indicate which ones.

___I was afraid to tell.
___It was my fault or I was partly to blame.
___I felt ashamed or embarrassed
___I didn't recall what happened until recently
___I didn't think it affected me that much
___I was threatened and told not to tell
___I didn't say no
___I didn't fight back
___I wanted to protect the person who hurt me
___I didn't know who to tell
___I did tell but no one believed me

Note: When under attack, the brains defense circuitry sends a signal to the body to respond by "flight, fight or freeze." No matter what you did or didn't do, any sexual abuse/assault you experienced was not your fault.

RISKS ASSOCIATED SEXUAL ABUSE OR ASSAULT

Many individuals who have experienced sexual abuse/assault have also experienced:

Check all that apply:

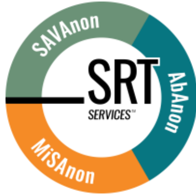
___ Past Abortion

___Miscarriage or Stillbirth

HOPE AND HEALING IS AVAILABLE

If you're concerned about how a past experience may be impacting your current life and health, we can help. We can discuss what options are available and help you determine which one is best for you.

Signature **Date**

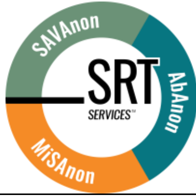


SRT SERVICES
TRAUMA SCREENING TOOL

If not dealt with, sexually related trauma can result in PTSD or Post Traumatic Stress Disorder. *Although the diagnoses of PTSD can only be made by a trained, licensed professional, the following screening tool can be useful.*

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

	In The Past Month, How Much Were You Bothered By:	**Not At All**	**A Little Bit**	**Moderatel y**	**Quite A Bit**	**Extremel y**
1.	Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2	Repeated, disturbing dreams of the stressful experience	0	1	2	3	4
3	Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4	Feeling very upset when something reminded you of the stressful experience	0	1	2	3	4
5	Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6	Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7	Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8	Trouble remembering important parts of the stressful experience	0	1	2	3	4
9	Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10	Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11	Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12	Loss of interest in activities that you used to enjoy?	0	1	2	3	4



13	Feeling distant or cut off from other people?	0	1	2	3	4
14	Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15	Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16	Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17	Being “super-alert” or watchful or on guard?	0	1	2	3	4
18	Feeling jumpy or easily startled?	0	1	2	3	4
19	Having difficulty concentrating?	0	1	2	3	4
20	Trouble falling or staying asleep?	0	1	2	3	4

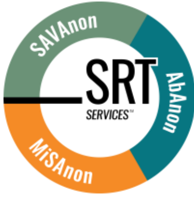
PCL-5 (11 April 2018) National Center for PTSD[4]

A total score of **30 or higher** suggests the client may benefit from TRC Services.

If not dealt with, sexually related trauma can result in PTSD or Post Traumatic Stress Disorder. *The diagnoses of PTSD can only be made by a trained, licensed professional.*

Total Score: _____

Signature **Date**



SRT Services
PAST ABORTION INFORMATION:

NAME: **DATE OF BIRTH:**

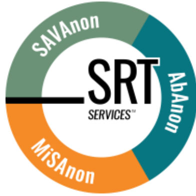
TODAY'S DATE:

What was your approximate age when you experienced your first abortion? _____
Number of abortions you have experienced? ____

It is not uncommon for someone who has experienced a past abortion to feel some of the following emotions. Check all that apply:

___Depression
___Anxiety
___Anger
___Difficulty Sleeping
___Nightmares
___Unhealthy obsessions
___Eating disorders
___Suicidal thoughts or attempts
___Self-harm cutting
___Casual sex
___Alcohol/drug abuse
___Addiction
___Phobias

If you have had an abortion, your current struggles could be the result of emotional trauma. Post Abortion Stress Syndrome (PASS) describes the effects that are common to men and women who have experienced past abortion(s).

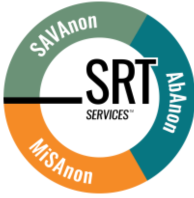


POST ABORTION STRESS SYNDROME SELF ASSESSMENT

	Feelings of loss
	Depression that is Stronger Than Just 'A Little Sadness or The Blues'
	Self-harm
	Cutting
	Strong Suicidal Thoughts or Suicide Attempts
	Increase In Dangerous and/or Unhealthy Activities (Alcohol/Drug Abuse, Anorexia/Bulimia)
	Compulsive Over-Eating
	Casual and Indifferent Sex and Other Inappropriate Risk-Taking Behaviors
	Inability to Perform Normal Self-Care Activities
	Inability to Function Normally in Her Job or In School
	Inability to Take Care of Or Relate to Her Existing Children or Function Normally in Her Other Relationships (I.E. With A Spouse, Partner, Other Family Members or Friends)
	A Desire to Immediately Get Pregnant And 'Replace' The Baby That Was Aborted, Even When the Circumstances That Led Her To 'Choose Abortion' The First Time Are Still in Place

Some PASS symptoms may not appear for months or even years following an abortion

	Emotional issues
	Anxiety and panic disorder
	Difficulty sleeping and sleeping problems
	Disturbing dreams and/or nightmares
	Problems with phobias, or increase in severity of existing phobias
	Repeated unplanned pregnancies with additional abortions
	Repeated unplanned pregnancies carried to term
	"Atonement marriage", woman marries the partner from the abortion, to help justify the abortion
	Distress at the sight of or socializing with other pregnant women, other people's babies and children
	Codependence and inability to make decisions easily
	Problems with severe and disproportionate anger
	Distress and problems with later pregnancy
	Added emotional issues and problems when dealing with future infertility or other physical complications resulting from the abortion
	Unhealthy obsession with excelling at work or school, to justify the abortion \Obsessive Pro-life or Pro-choice activism
	A lesbian lifestyle



RISKS ASSOCIATED WITH PAST ABORTION(S)

Many individuals who have had a past abortion may have also experienced:

Check all that apply:

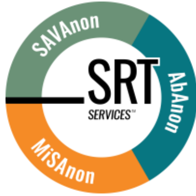
___Sexual Abuse or Sexual Assault

___Miscarriage or Stillbirth

HOPE AND HEALING IS AVAILABLE

If you're concerned about how a past experience may be impacting your current life and health, we can help. We can discuss what options are available and help you determine which one is best for you.

Signature **Date**



SRT SERVICES
TRAUMA SCREENING TOOL

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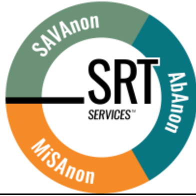
	In The Past Month, How Much Were You Bothered By:	**Not At All**	**A Little Bit**	**Moderately**	**Quite A Bit**	**Extremely**
1.	Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2	Repeated, disturbing dreams of the stressful experience	0	1	2	3	4
3	Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4	Feeling very upset when something reminded you of the stressful experience	0	1	2	3	4
5	Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6	Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7	Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8	Trouble remembering important parts of the stressful experience	0	1	2	3	4
9	Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10	Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11	Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12	Loss of interest in activities that you used to enjoy?	0	1	2	3	4



13	Feeling distant or cut off from other people?	0	1	2	3	4
14	Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15	Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16	Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17	Being “super-alert” or watchful or on guard?	0	1	2	3	4
18	Feeling jumpy or easily startled?	0	1	2	3	4
19	Having difficulty concentrating?	0	1	2	3	4
20	Trouble falling or staying asleep?	0	1	2	3	4

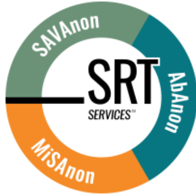
PCL-5 (11 April 2018) National Center for PTSD[4]

A total score of **30 or higher** suggests the client may benefit from TRC Services.

If not dealt with, sexually related trauma can result in PTSD or Post Traumatic Stress Disorder. *The diagnoses of PTSD can only be made by a trained, licensed professional.*

Total Score: _____

Signature **Date**



SRT SERVICES
MISCARRIAGE OR STILLBIRTH INFORMATION

NAME: **DATE OF BIRTH:**
TODAY'S DATE:

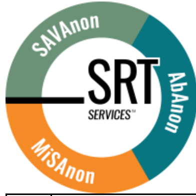
YOU ARE NOT ALONE:

1 in 4 pregnancies end in miscarriage or stillbirth
Miscarriage: Loss of a baby before the 20th week of pregnancy
Stillbirth: Loss of a baby at or after the 20th week of pregnancy

Men and Women who have experienced a miscarriage or stillbirth are often initially overwhelmed with sorrow and grief. Grief is the natural response to loss characterized by emotional suffering and pain. It can affect every area of life, including relationships.

MISCARRIAGE OR STILLBIRTH SELF ASSESSMENT
Check all that apply to you

	EMOTIONALLY	
	Sadness	
	Anger	
	Fear	
	Guilt	
	Helplessness	
	Depression	
	Shame	
	PHYSICALLY OR BEHAVIORALLY	
	Changes In Sleep	
	Changes in Appetite	
	Emptiness	Felt Physically in The Chest, Stomach, Or Elsewhere in The Body
	Restlessness	Inability To Sit Still or Concentrate
	Lethargy	Exhaustion Or Loss of Energy
	Tears	Grief Bursts That Can Occur at Unexpected Times
	Distracted Behaviors	Constant Work or Relocation; Self Destructive or Addictive Behaviors



	Reminiscing	Telling Or Retelling Stories About the Pregnancy or Loss of Child;
	COGNITIVELY	
	Disbelief	Feeling As Though the Loss Isn't Real or An Inability to Believe It Happened
	Forgetfulness	Not Finishing What Is Started; Absentmindedness
	Poor Focus	Difficulty Concentrating on Tasks or Lack of Motivation
	Questioning	Asking Or Wondering Why the Loss Occurred
	Embarrassment	
	SPIRITUALLY	
	Searching For Meaning	Wondering About the Purpose in Life
	Altering Personal Beliefs	Values Or Beliefs May Be Questioned or Discarded
	A Sense of The Child's Presence	Hearing Their Voice, Seeing Their Face or Dreaming of The Child

RISKS ASSOCIATED WITH MISCARRIAGE & STILLBIRTH

Many women who have had a miscarriage or stillbirth have also experienced:

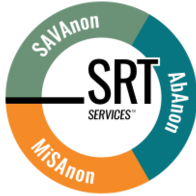
Check all that apply:

___ Past Abortion
___Sexual Abuse or Sexual Assault
___Multiple Miscarriage or Stillbirth

HOPE AND HEALING IS AVAILABLE

If you're concerned about how a past experience may be impacting your current life and health, we can help. We can discuss what options are available and help you determine which one is best for you.

Signature **Date**



SRT SERVICES
TRAUMA SCREENING TOOL

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2	Repeated, disturbing dreams of the stressful experience	0	1	2	3	4
3	Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4	Feeling very upset when something reminded you of the stressful experience	0	1	2	3	4
5	Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6	Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
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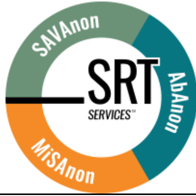
8	Trouble remembering important parts of the stressful experience	0	1	2	3	4
9	Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10	Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11	Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12	Loss of interest in activities that you used to enjoy?	0	1	2	3	4



13	Feeling distant or cut off from other people?	0	1	2	3	4
14	Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15	Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16	Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17	Being “super-alert” or watchful or on guard?	0	1	2	3	4
18	Feeling jumpy or easily startled?	0	1	2	3	4
19	Having difficulty concentrating?	0	1	2	3	4
20	Trouble falling or staying asleep?	0	1	2	3	4

PCL-5 (11 April 2018) National Center for PTSD[4]

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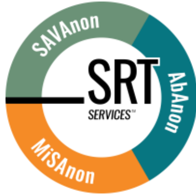
If not dealt with, sexually related trauma can result in PTSD or Post Traumatic Stress Disorder. *The diagnoses of PTSD can only be made by a trained, licensed professional.*

Total Score: _____

Signature **Date**

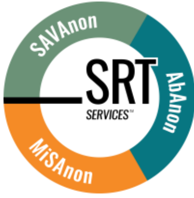


SRT SERVICES
PREGNANCY SERVICES INFORMATION

Name **Date of Birth** **Date**

1. Do you believe you are pregnant? ___Yes ___ No
2. Date of last menstrual period began: ________________________
3. What symptoms of pregnancy are you experiencing? Please explain:
   ____
   ____
   ____
4. Did you do a home pregnancy test? ___Yes ___No If so, when? ____________
5. Would you like to have a pregnancy test? ___ Yes ____ No
6. Have you been pregnant before? ___Yes ___No If yes, how many:
   ___Live births ___Abortions ___Miscarriages
7. Do you have a doctor? ___Yes ___No If yes, name of doctor: ___________________________
8. If pregnant, circle the number that best describes your feelings towards the child:
   Unwanted 1 2 3 4 5 Wanted
9. If pregnant, which of the following best describes your current plan?
   ___Keep the child ___Place the child for adoption ___Abort the child
10. What emotions are you currently feeling?

Scared	1	2	3	4	5	Fearless
Alone	1	2	3	4	5	Supported
Confused	1	2	3	4	5	Confident
Angry	1	2	3	4	5	Excited
Betrayed	1	2	3	4	5	Loved
Sad	1	2	3	4	5	Happy



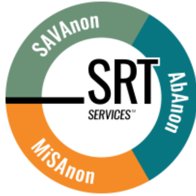
11. If pregnant, what are your greatest needs?
    1. ____
    2. ____
    3. ____

RISKS ASSOCIATED WITH PREGNANCY
Many individuals who have experienced pregnancy may have also experienced.
Check all that apply:

___ Past Abortion
___Sexual Abuse or Sexual Assault
___Multiple Miscarriage or Stillbirth

HOPE AND HEALING IS AVAILABLE
If you're concerned about how pregnancy or a past experience may be impacting your current life and health, we can help. We can discuss what options are available and help you determine which one is best for you.

Signature **Date**



SRT Services
STD INFORMATION

1. Do you believe you have an STD? ___Yes ___ No

2. What symptoms are you experiencing? Please explain:
   ____
   ____
   ____

3. Would you like to have an STD test? ___ Yes ____ No

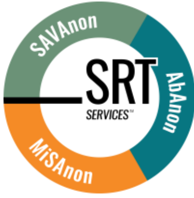
4. Have you been diagnosed with an STD before? ___Yes ___No If yes, when _____________
   What was your diagnosis? ____________

5. Do you have a doctor? ___Yes ___No If yes, name of doctor: __________________________

6. What emotions are you currently feeling? On a scale of 1 to 5, 1 being not at all and 5 being the highest, please circle.

Scared	1	2	3	4	5
Alone	1	2	3	4	5
Confused	1	2	3	4	5
Angry	1	2	3	4	5
Betrayed	1	2	3	4	5
Sad	1	2	3	4	5

7. If you test positive, what are your greatest needs?
   1. ____
   2. ____
   3. ____



RISKS ASSOCIATED WITH STD

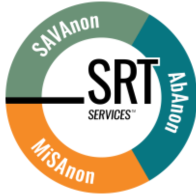
Many individuals who have had an STD have also experienced:

___Sexual Abuse or Sexual Assault
___Past Abortion
___Miscarriage/Stillbirth

HOPE AND HEALING IS AVAILABLE

If you're concerned about how an STD or a past experience may be impacting your current life and health, we can help. We can discuss what options are available and help you determine which one is best for you.

Signature **Date**



I SHOULD NEVER HAVE PUT MYSELF IN THAT POSITION

I WAS BORN WITH A TARGET ON MY BACK

HOW COULD I BE SO STUPID

I HATE MY LIFE

SEXUAL ASSAULT

UNLOVED, DIRTY, DEFECTIVE

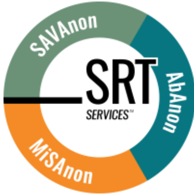
WHY DIDN'T I FIGHT BACK

I'LL NEVER BE THE SAME

I DESERVED IT

NO ONE WILL BELIEVE ME

Sexual ASSAULT



I AM A HORRIBLE PERSON

HOW CAN I EVER BE FORGIVEN

I AM WORTHLESS

I HATE SEEING SOMEONE WITH A BABY OR PREGNANT

INDECISIVE

WHAT IS WRONG WITH ME?

I AM UNWORTH OF FORGIVENES

I AM DESPERATE TO BE LOVED

YOU HAD CHOICES

HOW COULD I BE SO STUPID

WHY DIDN'T I REACH OUT FOR HELP

WHY DIDN'T I ASK IF HE WANTED KIDS BEFORE

I HATE MY LIFE

PAST ABORTION

UNLOVED, DIRTY, DEFECTIVE

WHY DIDN'T I USE MY VOICE

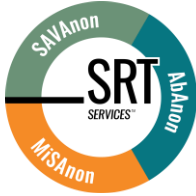
WISH I HAD NEVER BEEN WITH HIM

I HAVE SO MUCH ANGER

WISH I HADN'T PUT MYSELF IN THAT POSITION

I'M BETTER OFF DEAD

PAST ABORTION



I WILL NEVER BE GOOD ENOUGH

WHAT DID I DO WRONG?

I DON'T DESERVE TO HAVE CHILDREN

I AM DEFECTIVE

I HATE MY LIFE

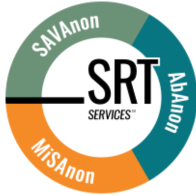
MISCARRIAGE

IT'S ALL MY FAULT

WHAT KIND OF GOD DOES THIS?

I'LL NEVER BE THE SAME

MISCARRIAGE



I SHOULD NEVER HAVE PUT MYSELF IN THIS POSITION

I WAS BORN WITH A TARGET ON MY BACK

HOW COULD I BE SO STUPID

I WILL BE ALL ALONE

I HATE MY LIFE

UNWANTED PREGNANCY

I DON'T KNOW HOW TO DO THIS

I DON'T EVEN LIKE THE FATHER

I'LL NEVER BE THE SAME

ABORTION IS BETTER THAN ADOPTION

WHY ME?

NO ONE WILL SUPPORT ME

MY DAD WAS RIGHT

UWANTED PREGANCY

I SHOULD NEVER HAVE PUT MYSELF IN THIS POSITION

I WAS BORN WITH A TARGET ON MY BACK

HOW COULD I BE SO STUPID

I HATE MY LIFE

STD

UNLOVED, DIRTY, DEFECTIVE

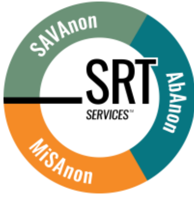
WHAT DO I DO NOW

I'LL NEVER BE THE SAME

WHY ME?

MY DAD WAS RIGHT

STD



SRT Services

CLIENT DIRECTED CARE PLAN

CLIENT NAME: **DATE:**

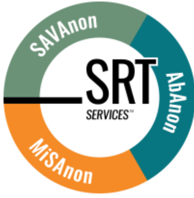
Care Coordinator:

LIFE WHEEL SCORES:

Input scores from Life Wheel Assessment below under Current Reality. Preferred Reality is the score the client will work towards in the coming months.

Life Areas:	Current Reality	Preferred Reality
Emotional		
Financial		
Intellectual		
Mental		
Physical		
Relational		
Social		
Spiritual		

NOTES:



Of the eight life areas from the Life Wheel, list in order your top three priorities.

CLIENT PRIORITES:

1.

2.

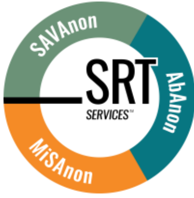
3.

PRIORITY NUMBER ONE:

1. **Common Purpose**
   "Why does this matter"

2. **Clear Expectations**
   "What does success look like?"

3. **Collaboration (Action Plan)**
   "How do we set this up for success?"



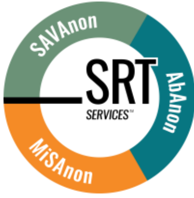
4. **Consequences or Success**
   "How could this go poorly? How could this go well? Learn and Act"

5. **Continued Support (Weekly Follow-up)**
   "How is it going? What adjustments are needed?"

RECOMMENED RESOURCES

CLIENT ACTIONS STEP(S):

ACTION ITEM: **DATE TO BE COMPLETED BY:**



PRIORITY NUMBER TWO:

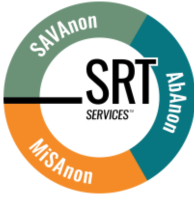
1. **Common Purpose**
   "Why does this matter"

2. **Clear Expectations**
   "What does success look like?"

3. **Collaboration (Action Plan)**
   "How do we set this up for success?"

4. **Consequences or Success**
   "How could this go poorly? How could this go well? Learn and Act"

5. **Continued Support (Weekly Follow-up)**
   "How is it going? What adjustments are needed?"

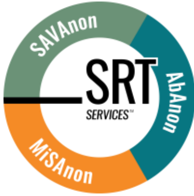


RECOMMENED RESOURCES

CLIENT ACTIONS STEP(S):

ACTION ITEM: **DATE TO BE COMPLETED BY:**

Notes:



PRIORITY NUMBER THREE:

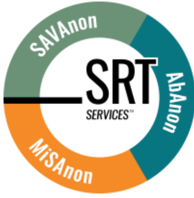
1. **Common Purpose**
   "Why does this matter"

2. **Clear Expectations**
   "What does success look like?"

3. **Collaboration (Action Plan)**
   "How do we set this up for success?"

4. **Consequences or Success**
   "How could this go poorly? How could this go well? Learn and Act"

5. **Continued Support (Weekly Follow-up)**
   "How is it going? What adjustments are needed?"



RECOMMENED RESOURCES

CLIENT ACTIONS STEP(S):

ACTION ITEM: **DATE TO BE COMPLETED BY:**

Notes:

NEXT PRIORITY:

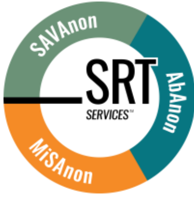
1. **Common Purpose**
   "Why does this matter"

2. **Clear Expectations**
   "What does success look like?"

3. **Collaboration (Action Plan)**
   "How do we set this up for success?"

4. **Consequences or Success**
   "How could this go poorly? How could this go well? Learn and Act"

5. **Continued Support (Weekly Follow-up)**
   "How is it going? What adjustments are needed?"



RECOMMENED RESOURCES

CLIENT ACTIONS STEP(S):

ACTION ITEM: **DATE TO BE COMPLETED BY:**

Notes:

Appointment Number _____:

Notes:

SRT Services

Sample Coaching Questions

1. **WELCOME CLIENT**

   How are you feeling?

2. **OVERVIEW OF TRC/SRT SERVICES**

   What questions do you have?
   What else are you hoping to get out of our time together today?

3. **CARE COORDINATOR INTRODUCTION**

   How are you feeling?
   What else would you like me to share?

4. **SCREENING & ASSESSMENT**

   I see your primary reason for the visit today was _________, how are you feeling? I am so glad you came in. I really think we can help.
   What else you would like me to know before we get started?
   What surprised you about the Information form?
   How do you think this trauma has affected your life?

5. **BRAIN DUMP EXERCISE**

   I'd like to invite you to do an exercise that will help us process all the emotions and thoughts you might be having right now.

   What are you thinking?
   How are you feeling
   What questions do you have?

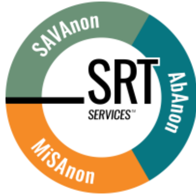
   Post Brain Dump Coaching Questions
   Begin asking open ended questions about what the client wrote on the paper. Don't evaluate, but instead stay curious.

   Example:
   Can you tell me more about this emotion?

6. **WHEEL OF LIFE ASSESSMENT**

   Let's look at your wheel. One area you are really strong in is…. tell me more?

   It looks like the area of your life you are least satisfied with is…….
   What things in your life would need to change for your ___________ to be an area of strength and satisfaction?



Can you picture your life with a full wheel? How would you describe your hopes and dreams for the future?

What obstacles will you face?

What threats do you feel would interfere with your dreams? Why?

7. OPTIONS COACHING – CURRENT AND PREFERRED REALITY

What can you tell me about your personality? How do you tend to respond to conflict? Stress?

When was the last time you faced a difficult decision? Can you tell me about that? How did you feel? What options did you have? What influenced your choice? How do you feel today about the choice you made? *(what can she learn from regrets/successes in past decisions)*

If money, time, people, or resources were not a problem, what options do you have?

What obstacles would you face?
What gives you peace?
What fears do you have?
What potential regrets would you have down the road?
What resources are available to help you with your concerns?

How do you feel about the conversations we have had?

What word best describes how you are feeling about the plan?

8. MAKE CONNECTIONS

9. CLIENT DIRECTED CARE PLAN

What are three goals you would like to start with?
Why does this matter?
What does success look like?
How do we set this up for success?
How could this go poorly? How could this go well?

10. IMPLENTATION OF CARE MODEL

How is it going?
What adjustments are needed?

11. CELEBRATE ACHIEVEMENTS

12. WORK THE PLAN

How is it going?
What adjustments are needed?