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# Client Intake Form (Counseling or Coaching)

In order to assist me to serve you in the very best manner, please fill out this form providing the information requested in the questions below. All information provided is held as confidential.

Please bring this form to your first session with me.

Name_____
First Middle Last

Address:_____
Street & Number

_____
City State Zip Code

Name of parent or guardian if under 18 years of age

Name_____
First Middle Last

Home Phone:_____May I leave a message here? Yes___No___

Cell Phone:_____May I leave a message here? Yes___No___

Email: _____May I email you here? Yes___No___

Would like to be on my email list for newsletter updates and special offers: Yes___No___

*Please thoroughly read, fill out and sign the HIPAA forms provided on my website regarding

Secure & Non-Secure Communications. Please bring these forms to your first counseling session.
**Email correspondence is not considered a confidential means of communication.
Birth Date: _____/_____/_____ Age:_____ Gender: Female___Male___

Relationship Status:
Never Married___Divorced___
Romantic Relationship___Domestic Partnership___Married___Separated___Widowed___
How long? _____

On a scale of 0-10 what is your current level of satisfaction?_____

Children & Ages_____

Who may I thank for referring you to my care? _____
How did you find me? _____

Mental Health History:

Please list any previous counseling, coaching or ministry care_____
When?_____With whom?_____

Are you now taking any prescription medications? Yes___No___
If so, please list_____

Have you ever been prescribed prescription medications? Yes___No___
If so, when and what medication?_____

General Health & Medical History:

1. Please rate your current physical health.
Poor Unsatisfactory Satisfactory Good Very Good

2. Please rate your current sleep quality.
Poor Unsatisfactory Satisfactory Good Very Good

3. How many times each week do you exercise? _____

What exercise do you do?_____

4. If you have any difficulties with your appetite or eating patterns please list them below:

_____

5. Are you now experiencing any overwhelming sadness, grief or depression? Yes___No___
If so, for how long? _____

6. In the past year have you experienced any suicidal feelings, thoughts or plans? Yes___No__
If so, have you made a suicide attempt? Yes___No___
If yes, please describe what happened _____
_____
_____

7. Do you currently experience any anxiety, panic attacks or phobias? Yes___No___
If so, when did it start? _____

8. Do you have any chronic or acute pain? Yes___No___
If so, of what nature and for how long? _____
_____
_____

Alcohol & Drug History:

9. Do you drink alcohol? Yes___No___ If so, how often?_____

10. Do you use any recreational drugs? Yes___No___If so, how often?_____-_____

11. Have you experienced any significant life changes or stressors in the past year?
Yes___No___If so, please describe_____
_____
_____
How do you believe you have adjusted to these changes?_____
_____

What would you like to be better in your adjustment?

_____

_____

Family Mental Health History:

Please indicate any of the following difficulties within your family history:

Alcoholism or Drug Abuse: Yes__No__ Who?_____

Anxiety, Panic Attacks or Phobias: Yes___No___Who?_____

Bi-Polar Disorder: Yes___No___Who?_____

Depression: Yes___No___Who?_____

Domestic Violence: Yes___No___Who?_____

Eating Disorders: Yes___No___Who?_____

Homelessness: Yes___No___Who?_____

Obesity: Yes___No___Who?_____

Obsessions or Compulsive Behaviors: Yes___No___Who?_____

Personality Disorder: Yes___No___Who?_____

Post Traumatic Stress Disorder: Yes___No___Who?_____

Schizophrenia: Yes___No___Who?_____

Sexual Abuse: Yes___No___Who?_____

Suicide Attempts or Threats: Yes___No___Who?_____

Miscellaneous Information:

1. Are you employed? Yes___No___

If so, please describe your work_____

Do you enjoy it? Yes___No___

Is it stressful to you? Yes___No___If so, please describe_____

_____

_____

2. Are you spiritual or religious? Yes___No___If so, please describe your faith experience_____

3. Please describe your strengths: _____

4. Please describe your weaknesses: _____

5. Please describe what goals you would like to accomplish in your counseling or coaching experience with me as they relate to your success in life, relationships, work, health, etc. _____

6. On a scale of 0-10 please describe your level of commitment to achieving your goals with my professional assistance of helping you to remove the obstacles in your path and set reasonable expectations for success with action steps in each area.

0-10 _____

0-10 _____

0-10 _____

0-10 _____

0-10 _____