Life Solutions Coaching and Counseling

Life Coaching and Professional Counseling

Intake Form

Please provide the following information and bring it to your first session. Information you provide here is protected as confidential information.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status:
□ Never Married/Single □ Domestic Partnership □ Married □ Separated

□ Divorced □ Widowed

Name of spouse (if applicable): _____
(Last) (First) (Middle Initial)

Please list any children/age: _____

_____

Occupation: _____ Highest Level of Education: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No

Referred by (if any): _____

Have you previously received any mental health services (therapy, psychiatric services, etc.)?
□ No □ Yes

If yes, please list when and previous practitioner: _____

Are you currently taking any prescription medication?
□ No □ Yes

If yes, please list: _____

_____

Have you ever been prescribed psychiatric medication?
□ No □ Yes

If yes, please list and provide dates: _____

_____

General Health and Mental Health Information

1. How would you rate your current physical health? (please circle)

   Poor Unsatisfactory Satisfactory Good Very good

   Please list any specific health problems you are currently experiencing (headaches, body aches, stomach problems, etc.), and or any medical conditions or disabilities:

   _____

   _____

   Please list any previous hospitalizations for medical reasons:

   _____

2. How would you rate your current sleeping habits? (please circle)

   Poor Unsatisfactory Satisfactory Good Very good

   Please list any specific sleep problems you are currently experiencing:

   _____

3. How many times per week do you generally exercise? _____

   What types of exercise do you participate in? _____

4. Please list any difficulties you experience with your appetite or eating patterns:

   _____

5. Are you currently experiencing overwhelming sadness, grief or depression?
   □ No □ Yes

   If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
   □ No □ Yes

   If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
   □ No □ Yes

   If yes, please describe _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. Do you engage recreational drug use? □ No □ Yes

   If yes, how often? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

    If yes, for how long? _____

    On a scale of 1-10 (10 being the best), how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently?

    _____

    _____

12. Please review the following list of symptoms and check all that you are currently experiencing:

- □ Concerns about physical health
- □ Concerns about mental stability
- □ Loss of appetite/increased appetite
- □ Insomnia (inability to sleep)
- □ Hypersomnia (sleeping all the time)
- □ Loss of interest in things
- □ Low motivation
- □ Feeling spiritually disconnected
- □ Uncontrollable anxiety or worry
- □ Lack of self-confidence
- □ Poor body image
- □ Binging/purging food
- □ Inability to concentrate at work or school
- □ Crying spells
- □ Feeling “on top of the world”
- □ Nightmares
- □ Inability to control thoughts
- □ Mood swings
- □ Obsessions or compulsions with activities
- □ Feeling trapped in rooms or buildings
- □ Excessive consumption of alcohol
- □ Abuse of prescription or non-prescription drugs
- □ Blackouts or temporary loss of memory
- □ Tremors
- □ Hallucinations (seeing or hearing things that aren’t there)
- □ Feeling you are being watched or people are “out to get you”

Family Mental Health History:

In the section below, please identify if there is a family history of any of the following. If yes, indicate the family member's relationship to you in the space provided (i.e., mother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes / no	
Anxiety	yes / no	
Depression	yes / no	
Bipolar Disorder	yes / no	
Domestic Violence	yes / no	
Eating Disorders	yes / no	
Obesity	yes / no	
Obsessive Compulsive Behavior	yes / no	
Schizophrenia	yes / no	
Suicide Attempts	yes / no	

Additional Information

1. Are you currently employed? □ No □ Yes

   If yes, what is your current employment situation? _____

   Do you enjoy your work? Is there anything stressful about your current work?

   _____

   _____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

   If yes, please answer the following:

   Describe your faith or belief: _____

   Are you a member of a church? □ No □ Yes

   If yes, what church? _____

   How much influence does your religion or spirituality have on your day-to-day life?

   □ A lot □ A moderate amount □ A little □ None

3. What do you consider to be some of your strengths?

_____

_____

_____

_____

4. What do you consider to be some of your weakness?

_____

_____

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

_____

_____

Emergency Contact Information

Name: _____ Relationship: _____

Phone Number(s): _____

Address: _____