OPEN DOOR COUNSEL & LIFE COACHING

CLIENT INTAKE FORM

Please provide the following information for our records. Leave a question unanswered if you would prefer not to share, is irrelevant to your experience with Open Door Counsel & Life Coaching or would rather discuss directly with your coach.

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPPA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/ authorized representative to whom it pertains unless other permitted by law.

PERSONAL INFORMATION

Name: ______________________________ Date: ________________, 20 ______

Parent/Legal Guardian (if under 18): ______________________________

Date of Birth: ______________________ Age: __________ Gender: ____________

Address: ______________________________

Marital Status: ( ) never married ( ) married ( ) divorced ( ) separated ( ) widowed ( ) partnership

Main Phone: ______________________ Leave a message? ( ) yes ( ) no

Email Address: ______________________________

Referred by (if any): ______________________________

TREATMENT HISTORY

Have you previously received psychiatric services, professional counseling, or psychotherapy? ( ) yes ( ) no

Are you currently taking prescribed psychiatric medication (antidepressants or others)? ( ) yes ( ) no

If yes, please list: ______________________________

HEALTH INFORMATION

Do you currently have a primary physician? ( ) yes ( ) no

Are you currently seeing more than one medical health specialist? ( ) yes ( ) no

Please list any chronic physical symptoms or health concerns (pain, headaches, hypertension, diabetes, etc.):

____

Are you on meds to manage a physical health concern. ( ) no ( ) yes

HEALTH INFORMATION (continued)

Are you having any problems with your sleep? ( ) yes ( ) no

If yes, check applicable: ( ) Sleep too little ( ) Sleep too much ( ) Poor quality sleep ( ) Disturbing dreams ( ) other ____________________________

How many times per week do you exercise? __________________ Duration (if applicable)? ______________________

Are you having any difficulty with appetite or eating habits? ( ) no ( ) yes

If yes, check where applicable: ( ) Eating less ( ) Eating more ( ) Binging ( ) Restricting

Have you experienced significant weight change in the last 2 months? ( ) no ( ) yes

Do you regularly use alcohol? ( ) no ( ) yes

In a typical month, how often do you have 4 or more drinks in a 24-hour period? ___________________________

How often do you engage recreational drug use? ( ) daily ( ) weekly ( ) monthly ( ) occasionally ( ) never

Do you smoke cigarettes or use other tobacco products? ( ) yes ( ) no

Have you had suicidal thoughts recently? ( ) frequently ( ) sometimes ( ) rarely ( ) never

Have you had them in the past? ( ) frequently ( ) sometimes ( ) rarely ( ) never

Any suicide attempts? ( ) never ( ) yes, if yes, when ____________________________

How would you rate your overall current physical health? (circle one)

Poor Unsatisfactory Satisfactory Good Very Good

Have you ever experienced any of the following?

Extreme depressed mood	Yes / No
Dramatic mood swings	Yes / No
Rapid speech	Yes / No
Extreme anxiety	Yes / No
Panic attacks	Yes / No
Phobias	Yes / No
Hallucinations	Yes / No
Unexplained losses of time	Yes / No
Unexplained memory lapses	Yes / No
Alcohol/substance abuse	Yes / No
Frequent body complaints	Yes / No
Eating disorder	Yes / No
Body image problems	Yes / No
Repetitive thoughts or behaviors	Yes / No

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, uncle, etc.)

Difficulty	**Yes / No**	**Family member**
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	Yes / No	
Panic attacks	Yes / No	
Schizophrenia	Yes / No	
Alcohol/substance abuse	Yes / No	
Eating disorders	Yes / No	
Learning disabilities	Yes / No	
Trauma history	Yes / No	
Suicide attempts	Yes / No	
Chronic illness	Yes / No	

SOCIAL INFORMATION

Are you currently in a romantic relationship? ( ) no ( ) yes

If yes, how long have you been in this relationship? ____

On a scale of 1-10 (10 being the highest quality), how would you rate your current relationship? __________

In the last year, have you experienced any significant life changes or stressors? If yes, please explain:

____

____

OCCUPATIONAL INFORMATION

Are you currently employed? ( ) no ( ) yes

If yes, who is your currently employer/position? ____

If yes, are you happy with your current position? ____

Please list any work-related stressors, if any ____

____

RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious? ( ) no ( ) yes If yes, what is your faith? ___________________________

If no, do you consider yourself to be spiritual? ( ) no ( ) yes

COACHING

Are you seeking Coaching? If yes, continue, if not, skip down to the next section.

What type of coaching are you seeking? ___________________________

Life? Career? Professional? Wellness? Financial?

Have you ever had a coach before? ( ) yes ( ) no

If yes, what type of coach? ___________________________

Life? Career? Professional? Wellness? Financial? Other?

What do you desire to be the outcome of this coaching relationship? ___________________________

____

What strategies worked well for you? ___________________________

____

Why did that coaching relationship end? ___________________________

____

OTHER INFORMATION

What do you consider to be your strengths? ___________________________

____

What do you consider to be your weaknesses? ___________________________

____

What do you like most about yourself? ___________________________

____

OTHER INFORMATION (cont.)

What do you like least about yourself? ______________________________

____

What are coping strategies that you have used? ______________________________

____

What are your goals for therapy/coaching? ______________________________

____

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To the best of my knowledge, the above information is true and correct. By signing I acknowledge I am beginning services with Open Door Counsel & Life Coaching, and I do so of my own free will.

______________________________	______________________________
Please sign first & last name here Date	Open Door Counsel & Life Coaching (Kate Burie) Date

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