DEBBI MOLNAR, CERTIFIED LIFE COACH

CLIENT INFORMATION

All information provided in this intake is confidential and cannot be released without your consent.
It is important you take the time to answer the questions as thoroughly as possible.

First Name_____ Last Name_____

Address _____

City _____ State_____ Zip _____

Home Phone _____ Can I Leave A Message? ❑ Yes ❑ No

Work Phone _____ Can I Leave A Message? ❑ Yes ❑ No

Cell Phone _____ Can I Leave A Message? ❑ Yes ❑ No

Email _____

Date Of Birth: _____/_____/_____ Age:_____

Emergency Contact_____ Relationship _____

Home Phone (_____) _____ Cell Phone (_____) _____

Employment Status: ❑ Employed ❑ Full Time ❑ Part Time ❑ Unemployed ❑ Disabled
Education Status: ❑ Student ❑ Full Time ❑ Part Time

Occupation _____ Degree/Education Completed _____

Employer/School_____
Address _____

Responsible Party (If different than client)

First Name_____ Last Name_____

Address _____

City _____ State_____ Zip _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Work Phone: (_____) _____ Date Of Birth: _____/_____/_____ Age:_____

Referral Information

How did you hear about my services? _____

Is it okay to contact this person to thank them for the referral? ❑ Yes ❑ No Phone _____

Family-of-Origin Information

Please tell me about your family of origin (parents, step-parents, siblings, other caretakers: name, age, living/deceased, relationship description) _____

_____

_____

_____

_____

Were you adopted? ❑ Yes ❑ No Did/Do you know your birth parents? ❑ Yes ❑ No

Marital/Relationship Information

Current Relationship Status:

❑ Single ❑ Partnered ❑ Engaged ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Name of Partner/Spouse _____ Age _____ Length of Relationship _____

How long have you been or were you: ❑ Married_____ ❑ Living Together_____ ❑ Dating_____

Describe your relationship:_____

_____

_____

Previous relationships/marriages (name, length, what caused it to end): _____

_____

_____

_____

Children

Name Age Gender School/Occupation

_____

_____

_____

Briefly describe your relationship with each of your children: _____

_____

_____

_____

Current Family Structure

Please list your current family structure (name, age, relationship, where they're living)

_____

_____

_____

_____

_____

Medical/Mental Health Information

Please list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures and any other medical conditions you have had.

Age	Illness/Diagnosis	Treatment	Result

List all medications you are currently taking: (prescribed, over the counter, and others)

Medication	Dosage	Taken for	When started	Prescribed by

Please list current physician(s) or medical practitioners whose care you are under:

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Have you or any member of your family been treated for:

Schizophrenia ❑ Yes ❑ No If yes, who? _____

Bipolar Disorder ❑ Yes ❑ No If yes, who? _____

Major Depression ❑ Yes ❑ No If yes, who? _____

Substance Abuse or other Addictions ❑ Yes ❑ No If yes, who? _____

Other mental health issues in your family of origin _____

Please list any major family health issues (include family member and issue) _____

Have you ever received psychiatric or psychological services before? ❑ Yes ❑ No If yes, please list age, length of treatment, focus of treatment: _____

Have you ever thought about, discussed or attempted suicide? ❑ Yes ❑ No If yes, when? _____

If so, please describe _____

Symptoms/Problem Checklist

Please check any of the following that you feel apply to you

- ☐ 1. Depression
- ☐ 2. Hopelessness
- ☐ 3. Loneliness
- ☐ 4. Grief/Loss Issues
- ☐ 5. Anxiety/Nervousness
- ☐ 6. Fear
- ☐ 7. Panic
- ☐ 8. Suicidal Thoughts
- ☐ 9. Racing Thoughts
- ☐ 10. Obsessive Thoughts
- ☐ 11. Compulsions
- ☐ 12. Over Organized/Neat
- ☐ 13. Messy
- ☐ 14. Hoarding (difficulty getting rid of things)
- ☐ 15. Temper/Anger
- ☐ 16. Impulse Control Issues
- ☐ 17. Irritability
- ☐ 18. Self Control
- ☐ 19. Concentration/Focus
- ☐ 20. Memory Issues
- ☐ 21. Self Criticism
- ☐ 22. Low Self Esteem
- ☐ 23. Guilt
- ☐ 24. Tired/Weak
- ☐ 25. Lack of Motivation
- ☐ 26. Difficulty Making Decisions
- ☐ 27. Overwhelm
- ☐ 28. Issues with energy
  - ___Lack of Energy
  - ___Too Much Energy
- ☐ 29. Difficulty with Change
- ☐ 30. Life Transition Issues
  Specify _____
  _____
- ☐ 31. Trauma (Witness or victim)
  - ___Domestic Violence
  - ___Physical Abuse
  - ___Sexual Abuse
  - ___Emotional Abuse
  - ___Assault
  - ___Violence Crime
  - ___Natural Disaster
  - ___Other _____
  _____
- ☐ 32. Issues with Sleep
  - ___Insomnia
  - ___Difficulty falling asleep
  - ___Difficulty staying asleep
  - ___Sleeping too much
  - ___Nightmares/Terrors
- ☐ 33. Cultural/Religious Issues
- ☐ 34. Work Issues
- ☐ 35. School Issues
- ☐ 36. Career Issues
- ☐ 37. Financial Issues
- ☐ 38. Legal Problems
  Specify _____
  _____
- ☐ 39. Health Issue(s)
  Specify _____
  _____
- ☐ 40. Health Issue with a Family Member: Specify _____
  _____
- ☐ 41. Disabilities
  Specify _____
  _____
- ☐ 42. Learning Issues
  Specify _____
  _____
- ☐ 43. Self Destructive Behavior
  - ___Cutting
  - ___Eating Disorder
  - ___Picking (Skin, Nails, Hair)
  - ___Suicidal Ideation
  - ___Other _____
- ☐ 44. Relationship Issues
  - ___Spouse/Partner
  - ___Parents
  - ___Children
  - ___Siblings
  - ___Friends
  - ___Co-Workers
  - ___Boss
  - ___Other _____
  - ___Lack of Relationships
- ☐ 45. Addiction (current or in recovery)
  - ___Smoking
  - ___Alcohol
  - ___Marijuana
  - ___Drugs _____
  - ___Gambling
  - ___Sex
  - ___Internet
  - ___Other_____
- ☐ 46. Personality Traits
  - ___Shy
  - ___Assertiveness
  - ___Judgmental
  - ___Secretive
  - ___Suspicion
  - ___Jealousy
  - ___Other_____

Social/Other Information

Do you smoke? ❑ Yes ❑ No If yes, how much?_____

Do you drink alcohol? ❑ Yes ❑ No If yes, how much?_____

Do you drink caffeine products? ❑ Yes ❑ No If yes, how much?_____

Do you use other recreational drugs? ❑ Yes ❑ No If yes, how much?_____

On a scale of 0-10, where 0 is low and 10 is high, please rate your life in the following areas:

Well-Being (Physical Body) _____
Well-Being (Emotional) _____
Well-Being (Mental)_____
Well-Being (Spiritual) _____
Financial Freedom/Security _____
Family Relationships _____
Friendships _____
Romantic Relationship _____

Career Achievements _____
Environment – Home_____
Environment – Work _____
Overall Satisfaction _____
Service to Others _____
Joy _____
Guilt _____
Success_____

Generating your life vs. Reacting to the circumstances of your life _____

What is currently working in your life?

What are your areas of concern?

What are your strengths?

What are your weaknesses?

What are your biggest challenges?

Please list the objectives/end results and measurements of success that you would like to have by the time we finish our work together:

Objective 1 _____

Measurement of Success:

Objective 2 _____

Measurement of Success:

Objective 3 _____

Measurement of Success:

Objective 4 _____

Measurement of Success:

Objective 5 _____

Measurement of Success:

Is there anything else you would like me to know?

To the best of my knowledge, the information provided in this intake is correct. I will notify you of any changes in this information.

Client Name _____ Date _____

Client Signature_____