Client Intake Questionnaire

Please fill in the information below and email it to lconnectionscoach@gmail.com prior to your first session. Please note: information provided on this form is protected as confidential information.

Personal Information

Name: ____ Date: ______________________

Address: ____

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

Cell/Work/Other Phone: _________________________ May we leave a message? □ Yes □ No

Email: ____May we leave a message? □ Yes □ No

**Please note: Email correspondence is not considered to be a confidential medium of communication.*

DOB: ______________________________ Age: _______ Gender: ________________

Marital Status:

□ Never Married □ Domestic Partnership □ Married

□ Separated □ Divorced □ Widowed

Referred By (if any):

____

May I have permission to thank this person for the referral? □ Yes □ No   Initial: __________

Life Connections
Ph: (626) 885-4322
www.lconnections.org

History

Have you previously received any type of mental health or coaching services?

□ No □ Yes, what type of services: ____

Are you currently taking any prescription medication? □ No □ Yes
If yes, please list:

Medication name	Dosage	Frequency

Have you ever been prescribed psychiatric medication? □ No □ Yes
If yes, please list:

Medication name	Dosage	Frequency

General and Mental Health Information

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

Poor Unsatisfactory Satisfactory Good Very good

2. Please list any specific health problems you are currently experiencing:

____

____

3. How would you rate your current sleeping habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

4. Please list any specific sleep problems you are currently experiencing:

____

____

5. How many times per week do you generally exercise? ________________________________

- What types of exercise do you participate in? ________________________________

6. Please list any difficulties you experience with your appetite or eating problems:

____

____

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

- If yes, for approximately how long? ____

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

- If yes, when did you begin experiencing this? ________________________________

9. Are you struggling with suicidal thoughts? □ No □ Yes

- If yes, how often? (Please circle one)

Constantly Often Somewhat Not very much

10. Have you tried to commit suicide in the past? □ No □ Yes, If yes, when? _______________

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

- If yes, please describe:

____

____

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

13. How often do you engage in recreational drug use?
    □ Daily □ Weekly □ Monthly □ Infrequently □ Never

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

- If yes, for how long? ____

15. On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?

____

Family Mental Health History

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

	Please Circle		List Family Member
Alcohol/Substance Abuse	Yes	No	____________
Anxiety	Yes	No	____________
Depression	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?

____

____

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

____

____

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

- If yes, describe your faith or belief:

____

____

- Would you like to incorporate spiritual or religious beliefs in your treatment? □ No □ Yes
- Would you like for prayer to be part of your counseling? □ No □ Yes

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

____

____

____

5. What do you consider to be some of your weaknesses?

____

____

____

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

____

____

7. What are you seeking help for at this time?

____

____

- How much are you troubled by this? (Please circle one)

  Constantly Often Somewhat Not very much

8. What would you like to get out of our time together?

____

____

____

9. What are 5 things you LIVE about your life:

   1. ____
   2. ____
   3. ____
   4. ____
   5. ____