

Client Intake

First Name _____

Last Name _____

Street Address _____

City _____

State _____

Zip _____

Home Phone _____

Work Phone _____

Cell Phone _____

Email _____

Sex _____

Marital Status _____

Date of Birth _____

Place of Birth _____

Emergency Contact _____

Referred By _____

Number of Siblings _____

Sex and Ages of Siblings _____

Spouse's date of Birth _____

Number of Children/Sex and Ages _____

Spouses Place of Birth _____

Number of Spouses Siblings _____

Sex and Ages of Spouses Siblings _____

Have you ever had Coaching/Counseling? _____

Are you on any medications? _____

List all medications _____

Are you currently under the care of any health care professional? _____

Explain _____

Do you frequently suffer from stress? _____

Explain the source of your stress _____

Do you experience frequent headaches? _____

Have you ever been in any accidents? _____

Explain briefly the accidents _____

(You may use the page at the end of this form if you need more space)

Briefly detail any traumatic occurrences in your life i.e.: deaths, accidents
divorce, war, attack, and _

(You may use the page at the end of this form if you need more space)

Any Fall? _____

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Any Surgeries? _____

Intention for Coming? _____

Are there any other conditions that I should be aware of?

Explain _____

Please use the following page to explain in detail you feel you need to.

Detailed Explanations.