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Intake Form

Contact Information
Name: _____ Date of Birth: _____ Age: _____
Home Address: _____
Email Address: _____
Cell Phone: _____ Work Phone: _____
Which phone may I leave a message on? _____
Referred by: _____
Do I have permission to thank them for this referral? Yes: ___ No: ___

Relationship Status

First Marriage	Separated	Single (never married)
Widowed	Divorced	Significant Other
Remarried (after spouses' death)	Remarried (after divorced)	Cohabitating

Current Employment
Full-time: ___ Part-time: ___ Student: ___ Unemployed: ___ Retired: ___
Role/Position/Title: _____
Area(s) of Responsibility: _____
Years with Current Organization: _____ Years in Industry: _____

Education Background
Highest grade completed: _____
Degree(s): _____
Military Service: _____

Annual Household Income
$0-24,999: ___ $25,000-74,999: ___ $75,000-124,999: ___ $125,000+: ___

Medical/Health Information

Have you worked with a **Professional Counselor** before? Yes: ___ No: ___
If yes, with whom: _____ When: _____
Have you been hospitalized for mental health issues? Yes: ___ No: ___
If yes, with whom: _____ When: _____
Have you worked with a **Professional Coach** before? Yes: ___ No: ___
If yes, with whom: _____ When: _____
Have you worked with a **Spiritual Director** before? Yes: ___ No: ___
If yes, with whom: _____ When: _____

Medications
List medications you are currently taking:
Medication Name Reason Prescribing Doctor
_____
_____
_____
_____

Primary Care Physician Name: _____
Phone Number: _____

What is your physical condition at the present time?
Poor: ___ Fair: ___ Average: ___ Good: ___ Excellent: ___

How many hours/days a week do you exercise: _____

What is your emotional condition at the present time?
Poor: ___ Fair: ___ Average: ___ Good: ___ Excellent: ___

Emergency Contact or Parent/Guardian
Name: _____
Address: _____
Cell Phone: _____ Work Phone: _____

Signature: _____ Date: _____