Intake Summary

Identifying Information

Client Name: _____ **DOB: _____**

Insurance Type (if applicable): _____ **Insurance Carrier_____**

Insurance Carriers name: _____ **Insurance Carriers DOB:_____**

Insurance #_____ **Group #: _____**

Address: _____ **City_____**

State: _____ **Zip Code_____**

Cell Phone:_____ **E-mail: _____**

Date of Birth:_____ **Height_____ Weight _____**

Emergency Contact Name/Number/ Relationship to client_____

Married/Single/Divorced

Spouse Name or Significant Other_____

Please list the names and ages of your children and grandchildren:

_____

_____

Please list the names of those living with you and your relationship with them:

_____

_____

Client's Employment:_____ **Position/Title_____**

How long have you worked in this position: _____

How did you hear of Seasons Life Coaching and Counseling: Internet/Doctor Referral/Friend Referral/Other (please explain)_____

Presenting Problems:

_____
_____
_____
_____

Previous Mental Health and/or Drug or alcohol treatment: Yes/No

If yes, when, where, and duration of treatment:

_____
_____

History of Domestic Violence: Yes/No

Significant Physical Proglems:_____
_____
_____

Medications (list all):_____
_____

Depression Survey:

1. **Do you have depressed moods often?**
2. **Have you lost interest or pleasure in some or most activities?**
3. **Have you lost or gained 5-10 pounds recently (last three months):**
4. **Do you feel physically slow or sluggish?**
5. **Do you feel worthless or guilty?**
6. **Have you had thoughts, plan, or have attempted suicide?**

Anxiety Survey:

1. **Do you ever have heart palpitations or accelerated heart rate?**
2. **Do you experience sweating, trembling, or shaking?**
3. **Do you have now or in the past chest pain or discomfort?**
4. **Are you nauseated or have abdominal distress?**
5. **Do you feel dizzy, lightheaded, unsteady, or faint?**
6. **Would you describe yourself as ever experiencing an anxiety attack?**

General Survey:

1. **Do you exercise?**
2. **Do you have a hobby?**
3. **Are you well organized?**
4. **Do you have difficulty with goal setting?**
5. **Do you have goals that you are unsure how to meet?**
6. **Do you know the barriers to your goals?**
7. **Have you experienced feeling overwhelmed?**
8. **Have you recently experienced a life altering change such as pregnancy, childbirth, marriage, divorce, loss of loved one, or relocation?**
9. **Do you feel tired or unmotivated?**
10. **Do you feel stagnant?**

Have you ever had trouble with the following or been advised by your physician that you have a problem in one of these areas:

1. **Heart Disease** **Yes/No Explain:**_____
2. **High Blood Pressure** **Yes/No Explain:**_____
3. **Low Blood Pressure** **Yes/No Explain:**_____
4. **Cancer of any type** **Yes/No Explain:**_____
5. **Hypoglycemia** **Yes/No Explain:**_____
6. **Diabetes** **Yes/No Explain:**_____
7. **Stomach Problems** **Yes/No Explain:** _____
8. **Ulcers** **Yes/No Explain:** _____
9. **Constipation** **Yes/No Explain:**_____
10. **Diarrhea** **Yes/No Explain:**_____
11. **Urination Problems** **Yes/No Explain:**_____
12. **Thyroid** **Yes/No Explain:**_____
13. **Back Problems** **Yes/No Explain:**_____
14. **Kidney** **Yes/No Explain:**_____
15. **Arthritis** **Yes/No Explain:**_____
16. **Circulation Problems** **Yes/No Explain:**_____
17. **Asthma** **Yes/No Explain:**_____

Do you think you have an eating disorder?_____

Please Explain:

_____

_____

What is your history with the following:

Recreation Drugs **Yes/No**

Frequency/Type_____

_____

_____

Alcohol **Yes/No**

Frequency/Type_____

_____

_____

Sexual Problems: Desire or ability or function: Yes/No

Explain_____

_____

Sleep Problems Yes/No Explain

_____
_____

Do you adhere to any spiritual beliefs?

_____
_____