Optimal Life

Optimizing Life Through Mind, Body, & Soul

Confidential Client Intake Form

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Instructions: To assist me in helping you, please fill out this form. Answer only the questions you feel comfortable in answering,a keeping in mind that it is more helpful when you provide more detailed information. The information on this form will be held in the strictest of confidence.

Client Information

Name(s) of ALL person(s) being seen: _____

Date of birth: _____ Sex: M F

Full Address: _____

_____

Phone: _____ Email: _____

Best Times to Call You: _____

Is it okay to leave a message at the number provided? (Please Circle) Yes No

May I contact you by email? (Please Circle) Yes No

Does your family know you are seeking counselling or life coaching? _____ Partner _____

Father _____ Mother _____ Children _____ Friends _____ Other _____

Marital Status: (Please Circle)

Single Engaged Married Common-law Separated Divorced Widowed

Number of Children: _____

Family Physician's Name: _____ Phone#: _____

Are you currently employed: (Please Circle) Yes No

Your title at work: _____

Are you currently going to school: (Please Circle) Yes No

Type of Education: _____

Person to contact in case of emergency: _____

Their relationship to you: _____ Phone #: _____

How strongly do you want therapy for your problem(s): (please circle one)

Very Strongly Strongly Moderately Could do Without

How did you hear about Optimal Life Therapy?

_____

Please describe the issue(s) that you would like to work on in counselling or life coaching.

_____

_____

_____

_____

_____

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_____

_____

Please list your goal(s) for counselling or life coaching:

_____

_____

_____

Please read the following and circle yes or no.

Have you previously been involved in counselling or life coaching? Yes No

Are you currently taking any medication? Yes No If yes: _____

Do you drink alcohol, use prescription pain killers, sleep aids or use non-prescription drugs? Yes No

Have you ever been hospitalized for mental health reasons? Yes No

Is there a history of mental health issues in your family? Yes No

Do you currently have thoughts of suicide? Yes No

Do you intend to carry them out? Yes No

Have you ever attempted suicide? Yes No

Do you have a family history of suicide? Yes No

Have you ever been physically or emotionally abused? Yes No

Have you ever been sexually abused or assaulted? Yes No

Have you experience any violence in any of your relationships? Yes No

Please add any additional information which may be relevant: ____

_____

_____

_____

_____

_____

_____

_____

_____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. I certify that I have accurately answered the above questions.

_____ _____

Signature of Client (or parent of a minor) Date