COMPREHENSIVE
GASTROINTESTINAL HEALTH

BEHAVIORAL COACH AND COUNSELING INTAKE FORM

Client History

Please describe the current complaint or problem as specifically as you can, in your own words:

_____

_____

_____

How long have you experienced this problem, or when did you first notice it?

_____

_____

_____

What stressors may have contributed to the current complaint or problem?

_____

_____

_____

How is the current problem effecting your everyday life?

_____
(work)

_____
(social)

_____
(family)

Check all words/phrases that describe what you are experiencing dependently and/or independently of the above problem and explain if possible.

- ☐ Substance abuse/dependence
- ☐ Addiction
- ☐ Depression/Sad/Down feelings
- ☐ High/Low energy level
- ☐ Angry/Irritable
- ☐ Loss of interest in activities
- ☐ Avoiding certain activities (please specify)
- ☐ Difficulty enjoying things
- ☐ Crying spells
- ☐ Decreased motivation
- ☐ Withdrawing from people/Isolation
- ☐ Mood Swings
- ☐ Black and white thinking/All or nothing thinking
- ☐ Negative thinking
- ☐ Change in weight or appetite
- ☐ Change in sleeping pattern
- ☐ Suicidal thoughts or plans/ Thoughts of hurting yourself
- ☐ Self-harm/Cutting/Burning yourself
- ☐ Homicidal thoughts or plans/ Thoughts of hurting others
- ☐ Poor concentration/Difficulty focusing
- ☐ Feelings of hopelessness/Worthlessness
- ☐ Feelings of shame or guilt
- ☐ Feelings of inadequacy/Low self-esteem
- ☐ Anxious/Nervous/Tense feelings

- ☐ Panic attacks
- ☐ Racing or scrambled thoughts
- ☐ Bad or unwanted thoughts
- ☐ Flashbacks/Nightmares
- ☐ Muscle tensions, aches, etc.
- ☐ Hearing voices/Seeing things not there
- ☐ Paranoid thoughts/Thoughts that someone is watching you, out to get you or hurt you
- ☐ Feelings of frustration
- ☐ Perfectionism
- ☐ Rituals of counting things, washing hands, checking locks, doors, stove, etc./Overly concerned about germs
- ☐ Distorted body image
- ☐ Concerns about dieting
- ☐ Feelings of loss of control over eating
- ☐ Binge eating/Purging
- ☐ Rules about eating/Compensating for eating
- ☐ Excessive exercise
- ☐ Job problems
- ☐ Other:

Previous Treatment

Have you received or participated in previous behavioral coaching, counseling and/or therapy?

☐ Yes ☐ No

Have you ever participated in hypnotherapy? ☐ Yes ☐ No

Additional Information:

What did you like/dislike about previous treatment?

What did you learn about yourself through previous counseling/treatment that may help you?

Have you had hospital stays for psychological concerns? ☐ Yes ☐ No

Additional Information:

Are you currently experiencing thoughts of harming either yourself or someone else? ☐ Yes ☐ No

Have you in the past experienced thoughts of harming either yourself or someone else? ☐ Yes ☐ No

Are you satisfied at where you are in your life?

If not, where would you like to be?

Medical History

List any current or important past medications

Medication & Dose:

How would you rate your current physical health?

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Very Poor

Social History

Describe your relationship with peers and/or friends?

How would you describe your social support network?

Describe your hobbies/interests:

Describe any cultural concerns:

Occupational History

What is your current employment status?

- ☐ Employed Full-Time
- ☐ Employed Part-time
- ☐ Unemployed
- ☐ Self-employed
- ☐ Student
- ☐ Other

Are you satisfied with your employment? If not, why?:

_____

_____

_____

Marital History

Which best describes your marital status?

- ☐ Married, Date: _____
- ☐ Never Married
- ☐ Widowed, Date: _____
- ☐ Separated, Date: _____
- ☐ Divorced, Date: _____

If you are married, which best describes your marital satisfaction? ☐ Poor ☐ Fair ☐ Good ☐ Great

Do you have children? ☐ Yes ☐ No

If yes, complete the following for each:

First Name: _____

Age: _____

Gender: _____

Substance Use History

Are you currently or have you ever struggled with substance abuse? (alcohol, tobacco, marijuana, caffeine, or other) ☐ Yes ☐ No

Have you received treatment for substance use disorder? ☐ Yes ☐ No

Date of Treatment (Month, Year): _____

Outcome (Any Clean time?): _____

Summarize your goals for behavioral coaching, and counseling/therapy:

_____

_____

_____

What expectations do you have for behavioral coaching, counseling/therapy?

What are your strengths?

Is there any additional information that you believe it is important for your counselor to know in order to provide you with the best care possible?

Signature of client or guardian **Date**