



## BEHAVIORAL COACH AND COUNSELING INTAKE FORM

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

### Client History

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

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

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

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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.**

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|---|--|
| <input type="checkbox"/> Substance abuse/dependence                   | <input type="checkbox"/> Withdrawing from people/Isolation                           |
| <input type="checkbox"/> Addiction                                    | <input type="checkbox"/> Mood Swings   |
| <input type="checkbox"/> Depression/Sad/Down feelings                 | <input type="checkbox"/> Black and white thinking/All or nothing thinking            |
| <input type="checkbox"/> High/Low energy level                        | <input type="checkbox"/> Negative thinking   |
| <input type="checkbox"/> Angry/Irritable                              | <input type="checkbox"/> Change in weight or appetite                                |
| <input type="checkbox"/> Loss of interest in activities               | <input type="checkbox"/> Change in sleeping pattern                                  |
| <input type="checkbox"/> Avoiding certain activities (please specify) | <input type="checkbox"/> Suicidal thoughts or plans/<br>Thoughts of hurting yourself |
| <input type="checkbox"/> Difficulty enjoying things                   | <input type="checkbox"/> Self-harm/Cutting/Burning yourself                          |
| <input type="checkbox"/> Crying spells                                | <input type="checkbox"/> Homicidal thoughts or plans/<br>Thoughts of hurting others  |
| <input type="checkbox"/> Decreased motivation                         |  |

- 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?

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

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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?

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If not, where would you like to be?

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## Medical History

List any current or important past medications

Medication & Dose:

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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?

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How would you describe your social support network?

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Describe your hobbies/interests:

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Describe any cultural concerns:

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## 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?:

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## 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:

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

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**What are your strengths?**

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**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?**

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**Signature of client or guardian**

**Date**

