



CLIENT INTAKE FORM

Thank you for taking the time to fill out this form and provide us with details of your health

PERSONAL INFORMATION

FIRST NAME

LAST NAME

DATE OF BIRTH

GENDER

MALE FEMALE OTHER

CONTACT INFORMATION

EMAIL ADDRESS

PHONE NUMBER

CURRENT LOCATION (CITY, STATE)

HOW MAY I CONTACT YOU?

PHONE EMAIL

LIST YOUR CURRENT HEALTH/WELLNESS CONCERNS



COACHING PREFERENCES

Do you prefer video calls or phone sessions?

What methods help learn most effectively?

- Visual instruction
- Auditory methods
- Writing/Reading
- Kinesthetic (Hands-on)
- Other (If "Other", please specify _____)

How frequently do you need to review your progress to stay on track?

How do you respond to being criticized?

What motivates you?

What deters you from trying?

How can I best support you throughout this relationship?

CLIENT INTAKE QUESTIONS (CONTINUED)

Current Symptoms Checklist: (Check All That Applies)

- | | |
|--|---|
| <input type="checkbox"/> Depressed Mood | <input type="checkbox"/> Unable to Enjoy Activities |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Sleep Disturbance |
| <input type="checkbox"/> Anxiety Attacks | <input type="checkbox"/> Appetite Change |
| <input type="checkbox"/> Grief | <input type="checkbox"/> Excessive Guilt |

OTHER THAN YOUR TOP REASONS FOR RECEIVING SERVICES, WHAT ARE YOU LOOKING TO ACHIEVE?

(CHECK ALL THAT APPLY)

- More Meaning/Purpose in Life
- To Learn to Trust Myself More
- More Fulfilment/Happiness in Life
- More Balance in Life
- More Inner Peace in Life
- Other _____

WHICH AREAS OF YOUR LIFE DO YOU FEEL NEEDS THE MOST REPAIR?

(CHECK ALL THAT APPLY)

- Mental
- Physical
- Spiritual
- Emotional
- Social
- Financial

Name 3 of Your Best Personality Traits:

1

2

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