Center for Self Care Client Info

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential.

Name:

_____

(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____

(Last) (First) (Middle Initial)

Birth Date: ___ /___ /___ Age: _____ Gender ID: □Male □Female □Other

Address:

_____

(Street and Number)

_____

(City, State Zip)

Home Phone: (____)_____May we leave a message? □ Yes □ No

Cell/Other Phone:(____)_____May we leave a message? □ Yes □ No

E-mail: _____

May we email you? □ Yes □ No *Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any):

_____

Marital Status:

□ Never Married □ Domestic Partnership □ Married □ Separated □Divorced □ Widowed

Please detail any information about marriages and/or significant relations

_____

_____

Please list any children/age/health and wellbeing concern:

_____

_____

Please list any pets/age/health and wellbeing concern:

_____

_____

Please list the name and relevant details about anyone you take care of:

_____

_____

Have you previously received any type of coaching support, mental health services (psychotherapy, psychiatric services, etc)? □ No □ Yes

If yes, please list what was/is significant and why

_____

_____

Please list names of current or previous clinicians(s)/practitioner(s):

_____

_____

Are you currently taking any prescription medication? □ Yes □ No

If so, please list:

_____

_____

Are you currently taking any nutritional supplements including drinks?

□ Yes □ No

Please list and provide when and how you take them:

_____

_____

1. Are you currently employed? □ No □ Yes If yes, what is your current employment situation?

_____

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes If yes, describe your faith or belief:

_____

_____

3. What do you consider to be some of your strengths?

_____

_____

_____

_____

4. What do you consider to be some of your weaknesses?

_____

_____

5. What would you like to accomplish out of your time in therapy/coaching?

_____

_____

_____

_____

_____

Center for Self Care General Health And Wellbeing Information

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

_____

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing:

_____

_____

How many hours do you sleep? _____

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in?

_____

_____

4. Please list any difficulties you experience with your appetite or eating patterns:

_____

5. Are you currently experiencing overwhelming sadness, grief, or depression? □ No □ Yes If yes, for approximately how long?_____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this?_____

Are you aware of anything you do that helps yourself?

_____

7. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe where and what you do for it that helps:

_____

_____

8. Do you drink alcohol? □ No □ Yes If yes, please describe how much you drink: _____

_____

9. How often do you engage in drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

Past use?

_____

_____

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, 10 being the best, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently: Include events from past five years. If needed, use reverse side.

_____

_____

12. Who supports you in your life?

_____

_____

13. What in your life brings you the most enjoyment? (Use reverse side.)

_____

Family Health and Wellbeing History

How is the health of your mother? _____
How is the health of your father? _____

What is your ancestry?

_____

Who were your role models in health and wellbeing and self care?

_____

_____

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Please Circle	List Family Member(s)
Alcohol/Substance Abuse	
Abuse - Emotional/Physical/Sexual (Circle)	
Anxiety	
Depression	
Domestic Violence	
Eating Disorders	
Mood Disorders	
Obesity	
Obsessive Compulsive Behavior	
Schizophrenia	
Suicide Attempts	

Other (Please use next page to include any other relevant info)