***Balance for Life***

**Personal Consultant & Life Coach Service**

**Rick McCraw, MS**

[**Couples/Family**](http://www.rickmccraw.com/Individual_Intake.pdf) **Intake Form**

**To assist in helping you today, please provide the following information.**

**All responses are strictly confidential.**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Partner 1:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_** **DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip Code

**Sex: €** male € female € transgendered

**How would you prefer to be contacted?**

Home phone? □ yes □ no May we leave a message? □ yes □ no Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work phone? □ yes □ no May we leave a message? □ yes □ no Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell phone? □ yes □ no May we leave a message? □ yes □ no Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email for scheduling purposes only? □ yes □ no Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact:**  **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Partner 2:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip Code

**Sex:** □ male □ female □ transgendered

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Home phone? □ yes □ no May we leave a message? □ yes □ no Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work phone? □ yes □ no May we leave a message? □ yes □ no Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell phone? □ yes □ no May we leave a message? □ yes □ no Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Emergency Contact:**  **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital Status:** □ single □ married □ cohabiting □ separated □ divorced □ widowed □ dating

**Referred by:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list all members of your immediate household** (living with you)**:**

**Name Relationship Age**

1. ­­­­ / /
2. / /
3. / /
4. / /
5. / /

**Reason for Coming Today:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signs & Symptoms:**

Please mark all that apply by using 1 for partner 1, 2 for partner 2, and B for both:

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_ anger | \_\_ anxiety | \_\_ lack of coping skills | \_\_ abuse-physical |
| \_\_ confusion | \_\_ sexual concerns | \_\_ aggression/violence | \_\_ abuse-sexual |
| \_\_ fear/phobias | \_\_ depression | \_\_ suicidal thoughts | \_\_ abuse-emotional |
| \_\_ easily distracted | \_\_ sleeping problems | \_\_ racing thoughts | \_\_ social activities |
| \_\_ emotional | \_\_ family conflict | \_\_ financial stress | \_\_ negative self-talk |
| \_\_ marital concerns | \_\_ career/work related | \_\_ poor/unclear self-image | \_\_ low self-esteem |
| \_\_ indecision | \_\_ troubling behaviors | \_\_ feeling unhappy or blue | \_\_ caregiving issues |
| \_\_ medical problems | \_\_ parenting problems | \_\_ guilt or shame | \_\_ feeling worthless |
| \_\_ problems in school | \_\_ racing thoughts | \_\_ fear of dying | \_\_ helplessness |
| \_\_ housing | \_\_ domestic violence | \_\_ flashbacks | \_\_ social isolation |
| \_\_ excessive gambling | \_\_ panic attacks | \_\_ lack of motivation | \_\_ feeling numb |
| \_\_ shyness | \_\_ phobias | \_\_ fears | \_\_ mood swings |
| \_\_ absenteeism at work | \_\_ nerves | \_\_ withdrawal from friends | \_\_ difficulty relaxing |
| \_\_ legal problems | \_\_ eating disorder/issues | \_\_ body aches/ pains | \_\_ tearful |
| \_\_ friends | \_\_ addictive behaviors | \_\_ sadness | \_\_ poor impulse control |
| \_\_ stress | \_\_ grief/loss | \_\_ no friends | \_\_ headaches |
| \_\_ tiredness | \_\_ memory | \_\_ ambition | \_\_ making decisions |
| \_\_ hopelessness | \_\_ feeling inferior | \_\_ concentration problems | \_\_ bowel troubles |
| \_\_ irritability/on edge | \_\_ self-control | \_\_ temper | \_\_ appetite/weight |

\_\_ decrease in social & leisure activities \_\_ feeling down in the dumps \_\_ loss of interest in friends

\_\_ alcohol/drug abuse/addiction \_\_ loss of satisfaction in life \_\_ loss of interest in work

\_\_ other

**Please mark as above if there have been any recent** (2 months or less) **changes in the following:**

\_\_ Sleep patterns \_\_ Eating patterns \_\_ Behavior \_\_ Energy level \_\_ Mood swings \_\_ Physical activity level

\_\_ Weight \_\_ General disposition \_\_ Nervousness/tension \_\_ Sex drive

**This information will help you and your consultant begin to clarify your goals:**

**Have you ever been treated by a psychiatrist?** Partner 1: □ yes □ no Partner 2: □ yes □ no

Diagnosis; Partner 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_ Partner 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have either been hospitalized for mental health or chemical dependency treatment?** □ yes □ no

Diagnosis; Partner 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_ Partner 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you been to couples counseling before?** □ yes □ no **Was it helpful?** □ yes □ no

**Are you feeling suicidal now?** Partner 1:□ yes □ no Partner 2:□ yes □ no

**Have you ever attempted suicide?**  Partner 1:□ yes □ no When? \_\_\_\_\_\_ Partner 2:□ yes □ no When? \_\_\_\_\_\_\_\_

**Goals for Change:**

**What are your goals for change? What would you like to accomplish?**

**Partner 1:**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Partner 2:**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Thank you for taking the time to provide this information.**

**CREDIT CARD INFORMATION**

**REQUIRED FOR BOTH TELEHEALTH**

**AND**

**FACE-TO-FACE COUNSELING.**

**AUTHORIZATION**: By signing this **CREDIT CARD FORM**, you authorize me to charge the following credit/debit card for all fees not paid by cash or check.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name on Card Card Type Credit Card # Code

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address associated with card including street, city, and zip code Exp. Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date