Individual Client Information Questionnaire

Your cooperation in completing this questionnaire will be helpful in planning services for you. Please answer each item carefully. Ask your coach for clarification if you do not understand an item.

CLIENT INFORMATION:

Full Name:_____ Today's Date:_____

Date of Birth:_____ Marital Status:_____

Home Address:_____ City_____

State, Zip:_____ May we mail to you at this address? **Y☐ N☐**

E-mail address:_____ May we contact you by e-mail? **Y☐ N☐**

Home Phone:_____ May we phone you here? **Y☐N☐** Leave message? **Y☐ N☐**

Other Phone:_____ May we phone you here? **Y☐N☐** Leave message? **Y☐N☐**

Employer/School: _____ Occupation/Grade:_____

Who is financially responsible for payment? _____

SPOUSE OR PARENT INFORMATION: (if applicable)

Full Name:_____ Relationship to Client:_____

Date of Birth:_____ Marital Status: _____

Home Address:_____ City_____

State, Zip:_____ May we mail to you at this address? **Y☐ N☐**

E-mail address:_____ May we contact you by e-mail? **Y☐N☐**

Home Phone:_____ May we phone you here? **Y☐N☐** Leave message? **Y☐N☐**

Other Phone:_____ May we phone you here? **Y☐N☐** Leave message? **Y☐ N☐**

Employer/School: _____ Occupation/Grade:_____

OTHER INFORMATION:

Present Church Affiliation: _____

Who may we thank for referring you? _____

Emergency Contact Person (other than above) & Phone #: _____

Please list any previous coaching, EAP, counseling, or chemical dependency services you have used:

Provider Name Date Reason Was it helpful?

_____

_____

_____

What goals, concerns or problems bring you to coaching?

_____

_____

What changes would you like to see as a result of coaching?

List the members of your household:

Name	Age	Relationship to you	Is client the legal guardian?

MEDICAL HISTORY:

Primary Care Physician: _____ Date of Last Exam: _____

Please list all health problems (including allergies): _____

Current Medications:

Medication	Dosage	Doctor prescribing	Reason prescribed

Please list all past hospitalizations (medical, psychiatric, chemical dependency):

Date	Hospital	Reason

OTHER: