Focus Your Goals
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Standard Intake Questionnaire

1. What brings you to coaching currently? Is there something specific, such as a particular event? Be as detailed as you can.

   _____

   _____

2. What are your goals for coaching?

   _____

   _____

3. Have you seen a mental health professional before?
   Yes: _____ When? _____
   No: _____

4. Specify all medications and supplements you are presently taking and for what reason.

   _____

   _____

5. If taking prescription medication:
   Prescribing Doctor: _____

   Type of MD: _____
   Phone number: _____

6. Who is your primary care physician?
   Doctor: _____
   Type of MD: _____
   Phone number: _____

7. Do you drink alcohol?
   Yes: _____ How often? _____
   No: _____

8. Do you use recreational drugs?
   Yes: _____ Which drug? _____
   No: _____

9. Do you have suicidal thoughts?
   Yes: _____ No: _____

10. Have you ever attempted suicide?
    Yes: _____ Date: _____
    No: _____

11. Do you have thoughts or urges to harm others?
    Yes: _____ Date: _____
    No: _____

12. Have you ever been hospitalized for a psychiatric issue?
    Yes: _____ Date: _____
    No: _____

13. If you are in a relationship, please describe the nature of the relationship and months or years together.

    _____

14. Describe your current living situation.
    Live alone ___ With other ___

15. What is your level of education?

    Highest grade/degree: _____ Type of degree: _____

16. What is your current occupation? _____
17. How long have you been doing it? _____

18. Please check any of the following you have experienced in the past six months:

☐ Increased appetite	☐ Low motivation	☐ Anxiety
☐ Decreased appetite	☐ Isolation from others	☐ Fear
☐ Trouble concentrating	☐ Fatigue/low energy	☐ Hopelessness
☐ Difficulty sleeping	☐ Low self-esteem	☐ Panic
☐ Excessive sleep	☐ Depressed mood	
☐ Other:	☐ Tearful or crying spells	

Please explain: _____

19. Please check any of the following that apply:

- ☐ Headache
- ☐ High blood pressure
- ☐ Gastritis or esophagitis
- ☐ Hormone-related problems
- ☐ Head injury
- ☐ Angina or chest pain
- ☐ Irritable bowel
- ☐ Chronic pain
- ☐ Other: _____
- ☐ Loss of consciousness
- ☐ Heart attack
- ☐ Bone or joint problems
- ☐ Seizures
- ☐ Kidney-related issues
- ☐ Chronic fatigue
- ☐ Dizziness
- ☐ Faintness
- ☐ Heart valve problems
- ☐ Urinary tract problems
- ☐ Fibromyalgia
- ☐ Numbness & tingling
- ☐ Shortness of breath
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Asthma
- ☐ Arthritis
- ☐ Thyroid issues
- ☐ HIV/AIDS
- ☐ Cancer

20. What else would you like me to know?

_____