COACHING CLIENT INTAKE FORM

Disclaimer: Thank you for your interest in being a client of Golden Wings International Coaching, LLC. This form is used to collect information about new clients and for internal purposes only. The information you provide is confidential and will be treated accordingly.

PERSONAL INFO

Name: _____ **Date**: _____ **Date of Birth**: _____

Primary Care Physician: _____
-Do you give permission for ongoing regular updates to be provided to your primary care physician? ☐ Yes ☐ No

Current Coach: Martha Renee Kuhn **Coach Phone**: 1-318-349-8541
Email: Renee@GoldenWingsCoaching.com

REASONS FOR VISIT

What are the problems for which you are seeking help?

_____

_____

_____

Current Symptoms: (check all that apply)

☐ Racing thoughts
☐ Depressed mood
☐ Impulsivity
☐ Sleep pattern disturbance
☐ Avoidance
☐ Excessive worry
☐ Forgetfulness
☐ Unable to enjoy activities
☐ Fatigue
☐ Suspiciousness
☐ Loss of interest
☐ Change in appetite
☐ Anxiety attacks
☐ Excessive guilt
☐ Increased risky behavior
☐ Peyronie's Disease
☐ Family Issues
☐ Increased irritability
☐ Increased libido
☐ Work Stress
☐ Excessive energy
☐ Decreased libido

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☐ Decreased need for sleep
☐ Crying spell
☐ _____

SUICIDE RISK ASSESSMENT

Have you ever had feelings or thoughts that you didn't want to live? ☐ Yes ☐ No
If yes, please answer the following. If no, please skip to the next section.

-Do you **currently** feel that you don't want to live? ☐ Yes ☐ No
-How often do you have these thoughts? _____
-When was the last time you had thoughts of dying? _____
-Has anything happened recently to make you feel this way? ☐ Yes ☐ No
-On a scale of 1 to 10, how strongly do you feel these thoughts? _____
-Would anything make it better? ☐ Yes ☐ No
-Have you ever thought about how you would kill yourself? ☐ Yes ☐ No
-Is the method you would use readily available? ☐ Yes ☐ No
-Have you planned a time for this? ☐ Yes ☐ No
-Is there anything that would stop you from killing yourself? ☐ Yes ☐ No
-Do you feel hopeless and/or worthless? ☐ Yes ☐ No
-Have you tried to kill or harm yourself before? ☐ Yes ☐ No
If so, please explain how: _____

_____

-Do you have access to firearms? If yes, please explain below. ☐ Yes ☐ No

_____

PAST MEDICAL HISTORY

Do you have any allergies? If yes, specify them: _____

Current Weight: _____ **Current Height:** _____

List any prescription medication that you are currently taking and how often you are taking them:

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Medication	Total Daily Dosage	Estimated Start Date

Current over-the-counter medication or supplements: _____
Current medical problems: _____

Past medical problems, nonpsychiatric hospitalization, or surgeries:

_____

Have you ever had an EKG? ☐ Yes ☐ No
If yes, when? _____ How was the EKG? ☐ Normal ☐ Abnormal ☐ Unknown

For women only
Date of last menstrual period: _____ **Birth control method**: _____

Are you currently pregnant or do you think you might be pregnant? ☐ Yes ☐ No

Are you planning to get pregnant in the near future? ☐ Yes ☐ No

How many times have you been pregnant? _____ **How many live births?** _____

Any concerns about your physical health that you would like to discuss? ☐ Yes ☐ No
If yes, please specify:

Date of last physical exam: _____ **Location**: _____

PERSONAL AND FAMILY MEDICAL HISTORY

Check any that apply to you or a member of your family (specify who if selected):

1. Thyroid disease ☐ You ☐ Family member (_____)
2. Anemia ☐ You ☐ Family member (_____)
3. Liver disease ☐ You ☐ Family member (_____)
4. Chronic fatigue ☐ You ☐ Family member (_____)
5. Kidney disease ☐ You ☐ Family member (_____)

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6. Diabetes ☐ You ☐ Family member (_____)
7. Asthma/respiratory problems ☐ You ☐ Family member (_____)
8. Stomach or intestinal problems ☐ You ☐ Family member (_____)
9. Cancer ☐ You ☐ Family member (_____)
10. Fibromyalgia ☐ You ☐ Family member (_____)
11. Heart Disease ☐ You ☐ Family member (_____)
12. Epilepsy or Seizures ☐ You ☐ Family member (_____)
13. Chronic Pain ☐ You ☐ Family member (_____)
14. High Cholesterol ☐ You ☐ Family member (_____)
15. High Blood ☐ You ☐ Family member (_____)
16. Pressure ☐ You ☐ Family member (_____)
17. Head Trauma ☐ You ☐ Family member (_____)
18. Liver Problems ☐ You ☐ Family member (_____)
19. Other: _____ ☐ You ☐ Family member (_____)

Any other additional personal or family medical history?

_____

_____

_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth? ☐ Yes ☐ No
If yes, please specify:

_____

_____

PSYCHIATRIC HISTORY

Outpatient Treatment? ☐ Yes (if yes, specify the details below) ☐ No

Reason	Date Treated	By Whom
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Psychiatric Hospitalization? ☐ Yes (if yes, specify the details below) ☐ No

Reason	Date Hospitalized	Where

List any psychiatric medication you have taken, the dates, dosage, and any side effects:

Medication	Date.	Dosage	Side Effects

FAMILY PSYCHIATRIC HISTORY

Has anyone in your family been treated for:

☐ Bipolar disorder ☐ Depression ☐ Anxiety ☐ Anger ☐ Suicide ☐ Schizophrenia
☐ Post-traumatic stress ☐ Alcohol abuse ☐ Violence ☐ Other: _____

If any of the options were selected, specify the family member and the corresponding problem:

_____

_____

Has any family member been treated with psychiatric medication? If yes, who was treated, what medications did they take, and how effective was the treatment?

_____

_____

_____

_____

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SUBSTANCE USE

Have you ever been treated for alcohol or drug use or abuse? ☐ Yes ☐ No
-If yes, for which substances? _____
-If yes, where were you treated and when? Date: _____ Location: _____

How many days per week do you drink alcohol? ____

What is the least and the most # of drinks you will drink in a day? Least: ____ Most: ____

What is the most alcohol you have consumed in a day in the last 90 days? _____

Have you ever felt you should cut down on your drinking or drug use? ☐ Yes ☐ No

Have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No

Have you ever felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ☐ Yes ☐ No

Do you think you may have a problem with alcohol or drug use? ☐ Yes ☐ No

Have you used any street drugs in the past 3 months? ☐ Yes ☐ No
-If yes, which ones? _____

Have you ever abused prescription medication? ☐ Yes ☐ No
-If yes, which ones and for how long? _____

Have you ever tried any of the following?

Substance	If so, how long and when did you last use?
☐ Methamphetamine	_____
☐ Cocaine	_____
☐ Stimulants (pills)	_____
☐ Heroin	_____
☐ LSD or Hallucinogens	_____
☐ Marijuana	_____
☐ Painkillers (not as prescribed)	_____
☐ Methadone	_____

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☐ Tranquilizer/sleeping pills _____
☐ Alcohol _____
☐ Ecstasy _____
☐ Fentanyl _____
☐ Other: _____ _____
☐ Other: _____ _____
☐ Other: _____ _____

PERSONAL HABITS

How many caffeinated beverages do you drink a day? Coffee ____ Sodas ____ Tea ____

Have you ever smoked cigarettes? ☐ Yes ☐ No
Currently? ☐ Yes ☐ No

If yes, how many packs per day on average? ____
How many years have you smoked? _____

In the past? ☐ Yes ☐ No
If yes, how many years did you smoke? _____ When did you quit? _____

Do you exercise regularly? ☐ Yes ☐ No
How many days a week? _____
How much time each day? _____
What kind of exercise do you do? _____

PERSONAL DETAILS

Were you adopted? ☐ Yes ☐ No **Where did you grow up?** _____

List your siblings and their ages:

Name	Age

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What is/was your parent's occupation? Father: _____ Mother: _____

Did your parents divorce? ☐ Yes ☐ No
If yes, what age were you? _____
Who did you live with? _____

Describe your father and your relationship with him:

_____

_____

Describe your mother and your relationship with him:

_____

_____

How old were you when you left home? _____

Has anyone in your immediate family died? If yes, specify who and when:

_____

Do you have a history of being abused emotionally, sexually, physically, or by neglect? If yes, describe when, where, and by whom:
Highest education level attained? _____

Employment status: ☐ Working ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired
How long have you been in your present position? _____
If working or retired, what is/was your occupation? _____
What location do/did you work? _____

Have you ever served in the military? ☐ Yes ☐ No
What Country did you serve? _____
If yes, what branch? _____
When did you serve? _____
Were you honorably discharged? ☐ Yes ☐ No ☐ Other: _____

Marital Status: ☐ Married ☐ Partnered ☐ Divorced ☐ Single ☐ Widowed
How long have you been in your present status? _____

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If not married, are you currently in a relationship? ☐ Yes ☐ No
If yes, how long? _____

If you have a partner or spouse, what is their occupation? _____

Are you sexually active? ☐ Yes ☐ No
What is your sexual orientation? _____

Do you or your spouse have sexual complications or interference? ☐ Yes ☐ No
If yes, how long? _____

What are the complications or interferes?

_____
_____
_____
_____

How often do you have sex? _____
Does he enjoy it? ☐ Yes ☐ No
Does she enjoy it? ☐ Yes ☐ No

Is sex painful? ☐ Yes ☐ No

Describe your relationship with your partner or spouse:

_____

_____

Have you had any prior marriages? ☐ Yes ☐ No
If so, how many? ____ How long were/was the marriage(s)? _____

Was He sexually active before marriage? ☐ Yes ☐ No
Was she sexually active before marriage? ☐ Yes ☐ No

Do you have any children? ☐ Yes ☐ No
If yes, specify their age and sex:

Age	Sex
____	_____

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_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Describe your relationship with your children:

_____

_____

_____

_____

_____

List everyone who currently lives with you:

_____

_____

_____

LEGAL DETAILS

Have you ever been arrested? ☐ Yes ☐ No
Any pending legal problems? ☐ Yes ☐ No

SPIRITUAL DETAILS

Do you belong to a particular religion or spiritual group? ☐ Yes ☐ No
If yes, what is the level of your involvement? _____

If you are not here for Spiritual Coaching, please skip this section after answering the above questions.

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Background and Experience

Can you describe your spiritual or religious background?

What experiences have led you to feel that you have faced spiritual abuse?

How has this experience impacted your beliefs or spiritual practices?

Current Challenges

What specific feelings or thoughts are you struggling with as a result of this abuse?

How do you currently cope with these feelings?

Are there particular situations or triggers that intensify these feelings?

Goals for Coaching

What are your primary goals for our coaching sessions?

How would you like to see your relationship with spirituality change?

What skills or strategies do you hope to develop through coaching?

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_____
_____
_____

Support and Resources

Have you sought any previous support (therapy, counseling, support groups)? ☐ Yes ☐ No

If so, what was your experience?

_____
_____
_____

What support systems do you currently have in place (friends, family, community)?

_____
_____
_____

Closing Thoughts

Is there anything else you would like to share that may help in understanding your situation?

_____
_____
_____

What concerns do you have about the coaching process?

_____
_____
_____

KINSHIP CARE DETAILS

*****If you are not raising someone else's children, please skip this section.***
*****This section is for those who are seeking coaching for Kinship Care or Grandparents Raising Grandchildren Coaching.***

Basic Information

What prompted you to become a caregiver for your grandchild/grandchildren/kin?

_____
_____
_____

How long have you been in this caregiving role?

_____

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Can you describe your living situation and the dynamics within your household?

Understanding the Child(ren)

How many grandchildren or kin are you raising, and what are their ages?

What are some of the challenges your grandchild/grandchildren/kin are facing?

What are their strengths and interests?

Current Challenges

What specific challenges are you experiencing as a caregiver?

How do you feel about your current support system (family, friends, community)?

What concerns do you have regarding the child's emotional or behavioral well-being?

Goals for Coaching

What are your primary goals for our coaching sessions?

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What skills or strategies do you hope to develop to support your grandchild/grandchildren/kin?

How would you like to improve your own well-being while caregiving?

Resources and Support

Have you accessed any resources or support services for caregivers?

If so, what has been your experience?

What additional support do you feel you need right now?

Other Concerns

Is there anything else you would like to share about your experience as a caregiver?

What concerns do you have about the coaching process?

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ACKNOWLEDGMENT

Signature: _____

Date: _____

Print Name: _____

Full Address: _____

Country: _____

Phone Number: _____

Email Address: _____

Emergency Contact: _____

Relationship: _____

Phone Number: _____

Email Address: _____

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