Rusty Nokes Coaching INTAKE FORM

Full Name_____ Today's Date_____
Male_____ Female_____ Date of Birth_____ Age_____
Home Address_____
City_____ State_____ Zip Code_____
Home Telephone_____Is it OK to contact you at home?___OK to leave message?_____
Mobile Telephone_____Is it OK to contact this number?_____OK to leave message?____

How did you learn about the coaching services provided by Net Cutters Addiction Recovery Coaching?_____

REASON FOR SEEKING COACHING:
Please briefly describe the problems/issues you are experiencing: _____
_____
_____
_____

What has happened to cause you to seek help now?_____
_____
_____

What do you hope to be able to do or achieve as a result of coaching?_____
_____

How do you handle stressors and/or cope with the problems you have described:_____
_____

Do you currently have thoughts of harming yourself? _____yes _____no
Have you in the past? _____yes _____no If YES, how long ago?_____

Do you currently have thoughts of wishing you were dead? _____yes _____no
Do you currently have urges to hurt, harm, or kill someone else? _____yes _____no
If YES, please explain:_____

Have you ever seriously considered suicide or felt like harming someone else?____yes ____no
If yes, please explain:_____

Name of current Psychiatrist and phone #:_____

Have you ever had previous coaching/therapy/counseling of any kind? ___yes ___no If yes, when, with whom, and for how long?_____

Have you ever been hospitalized for emotional problems? ___yes ___no Or for substance abuse problems? ___yes ___no If yes to either of the above, please note when, where, and for how long were you hospitalized?

Please check all of the items below that describe your situation:

___ Abuse/trauma – physical, sexual, emotional, neglect
___ Aggression, violence
___ Alcohol use
___ Anger, hostility, arguing, irritability
___ Anxiety, nervousness

___ Attention, concentration, distractibility
___ Career concerns, goals, and choices
___ Childhood issues
___ Codependence
___ Confusion
___ Compulsions and/or obsessions (thoughts or actions that repeal themselves)
___ Decision-making, indecision, mixed feelings, putting off decisions
___ Delusions (false ideas)
___ Dependence
___ Depression, low mood, sadness, crying
___ Divorce, separation, marital conflict, infidelity/affairs
___ Drug use - prescription medications, over-the-counter medications, street drugs
___ Eating problems - overeating, undereating, appetite, vomiting
___ Emptiness
___ Failure
___ Fatigue, tiredness, low energy
___ Fears, phobias
___ Financial or money troubles, debt, impulsive spending, low income
___ Gambling
___ Grieving, mourning, deaths, losses, divorce
___ Guilt
___ Headaches, other kinds of pains
___ Health, illness, medical concerns, physical problems
___ Inferiority feelings Impulsiveness, loss of control, outbursts
___ Irresponsibility
___ Judgment problems, risk taking
___ Legal matters, charges, suits
___ Loneliness Memory problems
___ Mood swings
___ Oversensitivity to rejection
___ Panic or anxiety attacks
___ Perfectionism
___ Pessimism
___ Procrastination, lack of motivation
___ Relationships problems (with friends, with relatives, or at work)
___ School problems
___ Self-centeredness
___ Self-esteem
___ Self-neglect, poor self-care
___ Sexual issues, dysfunctions, conflicts, identity issues
___ Sleep problems (too much, too little, insomnia, nightmares)
___ Spiritual, religious, moral, ethical issues
___ Stress and tension
___ Suspiciousness
___ Suicidal thoughts
___ Temper problems, self-control, low frustration tolerance
___ Thought disorganization and confusion
___ Threats, violence
___ Weight and diet issues
___ Withdrawal, isolation
___ Work problems, employment issues

SUBSTANCE USE HISTORY:

Have you ever experienced a problem with alcohol, drugs, or prescription medications?
If yes, please explain: _____
_____
_____

Have you ever been treated for problems with alcohol, drugs, or abuse or prescription medications?
___yes ___no If yes, please explain: _____
_____

Has anyone (family, doctors, friends, coworkers, bosses, etc.) ever expressed concern that you might have a problem with alcohol or drugs?___ yes ___ no If, yes, please explain: _____

Have you had any problems related to use of alcohol/drugs in the past year? ___ yes ___no
If, yes, please explain: _____
_____

Has drinking or drug use ever caused you problems in the following areas (check if yes):
__family __school __employment __legal __emotional __social __financial __behavior __physical health

FAMILY BACKGROUND: PLEASE CHECK THIS BOX IF YOU HAVE NO CHILDREN___

Names of Children	Living with you?	Age	Grade	School
_____	__yes __no	___	_____	_____
_____	__yes __no	___	_____	_____
_____	__yes __no	___	_____	_____
_____	__yes __no	___	_____	_____
_____	__yes __no	___	_____	_____

Other than any children already indicated above, who lives in your household? _____

Please describe your relationships with other family members:

Relationship	Living?	Describe quality of relationship
Father	__yes __no __n/a	_____
Mother	__yes __no __n/a	_____
Step-father	__yes __no __n/a	_____
Step-mother	__yes __no __n/a	_____
Spouse/partner	__yes __no __n/a	_____
Sister	__yes __no __n/a	_____
Brother	__yes __no __n/a	_____
Other	__yes __no __n/a	_____

Whom were you raised by*?* _____

Were you adopted? __yes __ no If so, at what age? _____

What family member(s) were you closest to as a child? _____
_____What family members(s) are you closest to now*?* _____
_____

Check the statement(s) below that describe the type of family you grew up in:

__overly close family __ no "breathing room" __ everyone was in everyone else's business __no privacy __boundaries not respected __comfortably close family __loving __shared many positive experiences __supportive __distant, everyone did their own thing __not much time spent together __not a lot of support __angry, lots of fighting/hostility __verbal abuse and conflicts __violence __ frightening __scared to make mistakes

Do you have any biological relatives ever had any emotional problems or substance abuse? __yes __no If yes, please
explain:_____

Has anyone in your family ever attempted or committed suicide? __yes __no
If yes, please explain: _____
_____

MARITAL STATUS:
Marital/relationship status (Check one) __Married __Live with partner (check if same__or opposite___ sex) __Single __Separated/Divorced __Widowed __Other:

Comments regarding stresses in current or previous marriage(s)/relationship(s): _____

_____

If you have had problems in the past, what do you think caused those relationships to end? _____

_____

Have you ever been abused mentally or physically by a romantic partner? __yes __no
Does this apply to your current relationship? __yes __no
Do you feel safe? __yes __no

EMPLOYMENT/EDUCATION INFORMATION: Check all that apply __employed __retired __disabled __student __homemaker __unemployed

*If/*When employed, what type of work do you do? _____

Current employer is: _____Years on current job: _____

Your income: _____ Total household income: _____

Highest degree completed in school: _____

HEALTH/MEDICAL INFORMATION:

Please list significant medical problems/conditions, and indicate if you are receiving treatment for them: _____

_____
_____

Do any of these problems affect your everyday life? __yes __no
If yes, how so?_____

Briefly describe any surgeries or hospitalizations for serious illness or injuries (What, where, when, etc.): _____

_____
_____

Have you ever blacked out / lost consciousness and/or experienced any type of serious head injury or trauma? __yes __no If so, please indicate when and what happened._____

List all medications that you currently use:

Medication(s) _____

Dosage (amount and times per day). _____

Reason(s). _____

Name of Medication Prescriber: _____

Name of Primary Care Physician (PCP): _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name: _____ Relationship_____

Address _____

Telephone # Daytime
_____ Evening_____

Cell Phone_____