

# Solutions For Life, Inc.

## Counseling, Life Coaching, and Consulting

### Client Intake Information Form

Welcome! As part of beginning the therapy process, please take a few minutes to fill out this form. This information will help me better understand your situation, and will help us both find solutions for your life that are creating difficulties. Please note this information is confidential.

Helping you discover Solutions for your life one session at a time.

Type of services sought (Check all that apply):

- Individual   
  Child/Teen   
  Martial/Couple   
  Family

### General Information

Client's Last Name	Initial	Client's First Name	Today's Date
Parent/Guardian (if client is under 18) _____			
Referred By: _____		May we thank them? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Reason for referral/choosing S4L? _____			
Faith/denominational preference? (if applicable): _____			
Your congregation/church/temple (if applicable): _____			
Is your religion/spirituality an important part of your life? (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No			
Emergency Contact: Name/Phone/Relation to you. _____			
Do you feel safe at home? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please explain _____			

### Employment/Education Information

Employment Status: <input type="checkbox"/> FT Employee <input type="checkbox"/> PT Employee <input type="checkbox"/> Unemployed <input type="checkbox"/> Student <input type="checkbox"/> Other _____	
Place of employment: (if applicable) _____	Length of employment?: _____ <input type="checkbox"/> Month(s) <input type="checkbox"/> Years
Type of work you do?: _____	
Highest level of education: (Adults Only) <input type="checkbox"/> High School <input type="checkbox"/> College Degree <input type="checkbox"/> Graduate Degree <input type="checkbox"/> Professional Training <input type="checkbox"/> Other _____	
Current Grade (Child and Adolescents Only) _____	

### Family Information

Martial Status: (Adults Only) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Living with Partner <input type="checkbox"/> Separated <input type="checkbox"/> Widow(er) <input type="checkbox"/> Divorced <input type="checkbox"/> Engaged					
Spouse / Partner's Name: _____	How long together, separated, divorced or deceased? _____				
Names of family members, living in the primary household (Please check those who will be attending counseling)					
<input type="checkbox"/>	Name	Relation	Age	Employer/School	Position/ Grade in school
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					
Names of family members, living outside of household (Please check those who will be attending counseling)					
<input type="checkbox"/>	Name	Relation	Age	Employer/School	Position/ Grade in school
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					