Form: CII

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Solutions For Life, Inc.

Client Intake Information Form

Counseling, Life Coaching, and Consulting

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

Family Information (cont.)

# of Children:	# of Children living with you?	#of Children living away?:
Have any of your children died? ☐ No ☐ Yes	If "Yes" when?	

Parents:

Mother: ☐ Living Age ____ ☐ Deceased When? ____

Father: ☐ Living Age ____ ☐ Deceased When? ____

Siblings:	☐ Only Child	# of Brothers	# of Sisters	# you place in family	# deceased

Check all that applied/apply while in childhood home. (please write who and what age you were during the experience.)

☐ Alcoholism	Age ____	who? ____	☐ Domestic Violence	Age ____	who? ____
☐ Death	Age ____	who? ____	☐ Mental Illness	Age ____	who? ____
☐ Divorce	Age ____	who? ____	☐ Sexual Abuse	Age ____	who? ____
☐ Remarry	Age ____	who? ____	☐ Drug Addiction	Age ____	who? ____

Other: ____

Other: ____

MEDICAL/PSYCHOLOGICAL HISTORY

Date of last physical? ____

Are you suffering any physical illnesses or symptoms at this time? ____

Are you currently under doctor's care? ☐ No ☐ Yes If "Yes" name of Doctor? ____

Reason for doctor's care? ____

Are you currently taking medication? ☐ No ☐ Yes If "yes" list below medication, dosage, and reason for medication.

Medication ____ Dosage? ____ Reason? ____

Medication ____ Dosage? ____ Reason? ____

List major surgeries or illnesses in the last five years: ____

Have you ever been hospitalized for a physical illness? ☐ No ☐ Yes If "Yes" reason(s) and date(s): ____

Do you smoke cigarettes? ☐ No ☐ Yes How many packs per day/week? ____

Do you drink alcohol? ☐ No ☐ Yes How many drinks per day/week? ____

Do you do drugs recreationally? ☐ No ☐ Yes What drugs and how often? ____

Has anyone ever been concerned about your alcohol/drug usage? ☐ No ☐ Yes Who? When? ____

Are you concerned about any family members alcohol/drug usage? ☐ No ☐ Yes Who? ____

Have you received psychotherapy or counseling in the past? ☐ No ☐ Yes When? ____

Name of Therapist? ____

Are you currently taking medication? ☐ No ☐ Yes If "yes" list below medication, dosage, and reason for medication.

Medication ____ Dosage? ____ Reason? ____

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