WellnessCoachingAndCounseling Intake Form

Client Information

Full Name: _____
Preferred Name (if different): _____
Date of Birth: _____ / _____ / _____
Age: _____
Gender Identity: _____
Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Other: _____
Phone Number: _____
Email Address: _____
Address: _____
Preferred Contact Method: ☐ Phone ☐ Email ☐ Text

Emergency Contact

Name: _____
Relationship: _____
Phone Number: _____

1. Reason for Seeking Services

Briefly describe your primary concerns or goals in seeking counseling and wellness coaching:

2. Mental Health & Medical History

- Have you received counseling or therapy before? ☐ Yes ☐ No
  If yes, when and with whom? _____
- Any diagnosed mental health conditions? ☐ Yes ☐ No
  If yes, please list: _____
- Current medications (mental health or other):

- Are you currently experiencing:
  ☐ Anxiety ☐ Depression ☐ Stress ☐ Grief/Loss ☐ Relationship Issues
  ☐ Trauma/PTSD ☐ Sleep Issues ☐ Substance Use ☐ Other: _____
- How would you rate your physical health?
  ☐ Excellent ☐ Good ☐ Fair ☐ Poor
- Do you have chronic illnesses or medical conditions? ☐ Yes ☐ No
  If yes, please specify: _____
- Do you exercise regularly? ☐ Yes ☐ No
- Do you follow any specific diet or nutrition plan? ☐ Yes ☐ No
  If yes, please describe: _____

3. Lifestyle & Support System

- Occupation: _____
- Relationship status: _____
- Do you feel supported by family/friends? ☐ Yes ☐ No
- Do you use alcohol/tobacco/drugs regularly? ☐ Yes ☐ No
  If yes, please describe use/frequency: _____

4. Goals & Expectations

1. What are your top 3 goals for counseling/wellness coaching?
   a. _____

b. _____
c. _____

2. How motivated are you to achieve these goals?
   ☐ Not at all ☐ Somewhat ☐ Motivated ☐ Very motivated

5. Informed Consent & HIPAA Authorization

A. Informed Consent for Services

- I understand that counseling and coaching services are voluntary and I may withdraw at any time.
- I understand the benefits and risks of these services.
- I agree to participate in sessions and follow the agreed-upon plan.

B. HIPAA Privacy Practices & Authorization

- I acknowledge that I have been provided with the "Notice of Privacy Practices" describing how my protected health information (PHI) may be used and disclosed.
- I understand my rights under HIPAA, including the right to request restrictions, to inspect and receive copies of my PHI, and to request corrections.
- I authorize WellnessCoachingAndCounseling to use and disclose my PHI for treatment, payment, and healthcare operations as outlined in the Privacy Notice.

Signature: _____
Date: _____ / _____ / _____

6. Telehealth Consent

- I consent to participate in telehealth sessions via video and/or phone.
- I understand telehealth has benefits and risks, such as technical issues or privacy concerns.
- I agree to a private, secure environment during sessions and will use encryption when possible.
- I understand that if connection fails, I will switch to phone or reschedule.

- I authorize the release of PHI necessary for telehealth purposes.

Client Signature (Telehealth Consent): _____

Date: _____ / _____ / _____