

# FAITH ASSEMBLY LIFE COACHING CENTER

## Intake Information and Questionnaire

Thank you for bringing your life coaching needs to us. Please answer the following questions so that we can better assist you. *Answers are confidential except where law requires reporting or disclosure.*

### Personal Information

Date \_\_\_\_\_

Name: \_\_\_\_\_ Spouse/Partner Name \_\_\_\_\_

Address: \_\_\_\_\_

Marital Status: (circle one) Single Married Separated Divorced Widow/Widower

Date of Birth: \_\_\_\_\_ Spouse Date of Birth: \_\_\_\_\_

Phone (day): \_\_\_\_\_ Phone (evening): \_\_\_\_\_

Emergency Contact Name and Phone # \_\_\_\_\_

### Marriage and Family

If applicable, have either you or your spouse been previously married? \_\_\_\_\_ If so, please explain the circumstances \_\_\_\_\_

Children (Indicate names, ages, and if they are step children or adopted): \_\_\_\_\_

### Health & Spiritual Life

Basic Physical Health: \_\_\_ Excellent \_\_\_ Good \_\_\_ Fair \_\_\_ Poor

Are you being treated for any specific illness? \_\_\_ Yes \_\_\_ No

Nature of the Illness: \_\_\_\_\_

Are you taking any medications (prescription or non-prescription)? \_\_\_ Yes \_\_\_ No

If "yes" name of drug(s) and what it treats: \_\_\_\_\_

Do you smoke? \_\_\_ Yes \_\_\_ No What and how much per week? \_\_\_\_\_

Do you consume alcohol? \_\_\_ Yes \_\_\_ No What and how much per week? \_\_\_\_\_

Continued on reverse side

Do you consider yourself a Christian and feel you are walking or living in a right relationship with God?

Yes  No Explain your answer: \_\_\_\_\_  
\_\_\_\_\_.

Do you attend church regularly? \_\_\_\_\_. If so, what church and what involvement do you have in the church? \_\_\_\_\_.

**Briefly answer the following questions:**

1. What is the main problem or issue that brings you here for life coaching?

2. What have you done in the past about the main problem or issue?

3. Are you currently seeing, or have you ever seen, a psychiatrist, psychologist, mental health practitioner, or received pastoral counseling? \_\_\_\_\_ If so, please explain the reasons/circumstances.

4. What are your expectations from your anticipated time with a spiritual care giver or life coach?

5. Is there any additional information we should know?

**Rate each issue (0 – 5) 0= no concerns; 3= some concerns; 5= serious concerns:**

<input type="checkbox"/> Spiritual Concerns	<input type="checkbox"/> Spiritual Confusion	<input type="checkbox"/> Physical Health Issues	<input type="checkbox"/> Physical Abuse
<input type="checkbox"/> Parenting Issues	<input type="checkbox"/> Sexual Abuse	<input type="checkbox"/> Depressed Feelings	<input type="checkbox"/> Gambling
<input type="checkbox"/> Self injury Behavior	<input type="checkbox"/> Anxiety Feelings	<input type="checkbox"/> Family Conflicts	<input type="checkbox"/> Dating Problems
<input type="checkbox"/> Poor Self Discipline	<input type="checkbox"/> Marital Issues	<input type="checkbox"/> Authority Conflict	<input type="checkbox"/> Fears
<input type="checkbox"/> Social Relationships	<input type="checkbox"/> Legal Issues	<input type="checkbox"/> Inferiority Feelings	<input type="checkbox"/> Grief
<input type="checkbox"/> Guilty Feelings	<input type="checkbox"/> Pornography	<input type="checkbox"/> Suicidal Thoughts	<input type="checkbox"/> Loneliness
<input type="checkbox"/> Alcohol Use	<input type="checkbox"/> Irritability	<input type="checkbox"/> Homicidal Thoughts	<input type="checkbox"/> Stress
<input type="checkbox"/> Sleeping Issues	<input type="checkbox"/> Finances	<input type="checkbox"/> Sexual Issues	<input type="checkbox"/> Forgiveness
<input type="checkbox"/> Divorce Issues	<input type="checkbox"/> Panic Thoughts	<input type="checkbox"/> Smoking	<input type="checkbox"/> Anger
<input type="checkbox"/> Strange Thoughts	<input type="checkbox"/> Drug Use	<input type="checkbox"/> Self Confidence	<input type="checkbox"/> Other (explain)