Shoray Kirk, Ph.D. Phone: 864-293-9994
A Coaching service

Client Information* Date: _____

*For couple's coaching, please complete two separate intake forms

Client Name:_____

Referred by:

Do I have your permission to thank them? Yes No

Address: _____ **Phone:** _____

_____ **Date of Birth:** _____

Gender: _____ **Soc. Sec. # (Optional):** _____

Marital Status (please circle): Single / Married / Partnered / Divorced / Widowed

Profession/Employment:

Education:

Email Address(s):

Please provide the name/number of an emergency contact:

Other Household member(s):

First name: Last name: Age: Relationship

_____
_____
_____
_____
_____
_____
_____
_____

Medical/Medications:

Name of family physician:

Are you currently on any medications or supplements? (include both prescription and non-prescription)

NAME	DOSAGE	REASON	EFFECTIVE?

What medications have you previously taken or been prescribed? Adverse side effects?

NAME	DOSAGE	REASON	EFFECTIVE?

Alcohol & other substances:

Do you: Smoke? Yes ___ No __ How much? _____ How Often? _____

Drink? Yes ___ No ____ How much? _____ How Often? _____

Have you ever used "recreational drugs" or "street drugs"? Yes No _____

PREVIOUS OR CURRENT THERAPY, PSYCHOLOGICAL OR PSYCHIATRIC TREATMENT

Have you previously (or currently) seen a mental health practitioner? Yes ___ No ___If so, whom do/did you see?

What were your reasons for seeking treatment then?_____

Have you previously had formal psychological testing? Yes _ No _ If yes, by whom?

DESCRIBE YOUR GOALS FOR SEEKING COACHING AT THIS TIME:

_____
_____
_____
_____
_____
_____
_____
_____

Please note that coaching is a self-pay service and is not covered by insurance.