Life Solutions Family Counseling and Coaching Center
3550 Parkwood Blvd Suite A 201
Frisco, Texas 75034
(214) 995-0007

Please fill out this form as completely as possible for your intake visit at Life Solutions.

Date _____

Name _____ Social Security Number _____

Address _____

City_____ State _____ Zip Code _____

Date of Birth_____ Age _____

Home Phone_____May we call you at this number? Yes___NO ___

Mobile Phone_____May we call you at this number? Yes___No ___

May we text you at this number? Yes___ No___

E-mail:_____May we email you? Yes___No ___

*Please note and be advised that E-mail or text correspondences are not considered to be confidential mediums and might compromise your sensitive information.

Are you currently employed? Yes___No___If yes, please answer the next 5 questions.

Place of Employment _____

Employer's Address _____

Date of employment_____Full-time_____Part-time_
Shift_____

Job title_____Military Service _____

Work Phone _____

Permission to call at work. Yes_____No _____

Family Doctor _____ Gynecologist _____

Are you taking any medication at this time? If so, please list _____

_____

Have you ever been hospitalized? Yes ___ No ___ If yes, please explain:

_____

_____

_____

Please list the dates of your hospitalizations: _____

_____

General Health and Mental Health Information

How would you rate your current physical health? (Please circle one)

Poor Fair Good Excellent

Pleas list any specific health problems you are currently experiencing:

_____ _____

Do you have trouble sleeping? Yes __ No __ If yes, please explain:

_____ _____

Do you experience difficulties with your eating habits? Yes __ No __ If yes, please explain:

_____ _____

How many times/week do you exercise? _____

What type of exercises do you do? _____

Are you currently experiencing extreme sadness, grief, depressive moods, or mood swings? Yes___No___If yes, for how long? _____

Are you currently experiencing fear, anxiety, panic attacks, or any kind of phobias? Yes___ No___If yes, please indicate what and for how long?

_____

Have you ever had thought of hurting or killing yourself? Yes __ No __ If yes, please Explain: _____

_____

Have you ever thought about hurting or killing someone? Yes __ No __If yes, please explain: _____

_____

Are there any guns in the house? Yes __ No __
If yes, are they in a safe under lock and Key? Yes __ No __.

Are you experiencing chronic pain? Yes __ No __ If yes, please explain: _____

_____

Do you drink more than once a week? Yes__ No __ If yes, please indicate your drink of choice and how many drinks: _____

_____

Do you engage in recreational drug use? Yes __ No __ If yes, how often do you use and what is your drug of choice: _____

Are you currently in a romantic relationship? Yes __ No __ If yes, for how long? _____
How do you rate your relationship? Poor __ Fair __ Good __ Excellent __ Please explain:

_____

Have you ever experienced sexual difficulties? If so, Please explain:

_____

Have you experienced any life changing or stressful event(s) in the last 6 months?
Yes___ No__If yes, please explain: _____

Information Concerning You and Your Family

Marital Status _____

If married, spouse's name _____ Number of Years Married _____

Spouse's Age_____ Place of Employment_____

If you are divorced, please list the names of previous spouse(s) and the number of years divorced _____

Please list names and ages of children:

_____
_____
_____

Has anyone in your family had counseling before? If so, who and for what reason?

_____
_____

Briefly describe what brings you to counseling now? _____

_____

_____

Who are the people in your life who mean the most to you? _____

_____

What is important to you? _____

_____

If you have a problem, who are you most likely to share it with? _____

_____

With whom do you enjoy spending time? _____

What do you consider to be your strengths?

_____

What do you consider to be your weaknesses?

_____

What are your interests? _____

_____

Do you enjoy your work? Yes __ No __ Please explain your stress level at work?

_____

_____

What are your plans for the future?_____

_____

What accomplishments are you are most proud of?_____

_____

Information Concerning You and Your Family Origin:

Describe your relationship with your parents (step-parents, if applicable), both currently and in the past.

	Past	Present
Mother		
Father		
Step mother		
Step father		

Please use the next few lines to share any additional information about your childhood or your relationship with your parents or step-parents: _____

_____

_____

_____

Please list the names of your siblings and their ages:

_____

_____

_____

Is there a history of drug or alcohol abuse in your family? If so, please describe.

_____

_____

Is there a history of sexual abuse in your family? If so, please describe.

_____

_____

Is there a history of physical abuse in your family? If so, please describe.

_____

_____

Has anyone in your family experienced any of the following conditions? (Please check all that apply and indicate the name of the family member and relationship to you.)

Alcohol/drug abuse
ADD/ADHD
Anxiety
Autism
Depression
Bipolar Disorder
Domestic violence
Eating disorders Obesity Bulimia Anorexia
Obsessive Compulsive Disorder (OCD)
Personality Disorder
Schizophrenia
Suicide (attempted or committed)

Consent for Obtaining Medical/Mental Health Records

If you have been treated by another physician, therapist/counselor and would like for us to send for additional information, counseling records, or medical records, please fill in the information below:

To (your doctor or counselor)

_____
Name

_____
Address

_____

_____

_____
Phone Number Fax Number

Please send my medical /counseling records to:

Life Solutions Family Counseling and Coaching Center
3550 Parkwood Blvd Suite A 201
Frisco, Texas 75034
Office: (214) 618-6888
Cell: (214) 995-0007
Fax: (972)625-9911

_____ _____
Signature Date