DesignerLifeStyles

Intake Application for Services

Application # ____________________

Name (please print): ____

Gender M F

Phone number(s) (H): ______________________ (W): ______________________

(Cell): ______________________

Mailing address: ____

City, State, ZIP: ____

Email: ____

How did you hear about us? ____

Best time(s) to contact you: ____

Please describe briefly what the problem is that you are experiencing or feel you need work with improving.

____

____

1. Please tell us what type of service or servies you would like to focus on (You may circle more than one.)

Career Assessment/testing
Individual/Personal Consulting
Couples Consulting/Counseling
LifeStyle Consulting
Child / Children issues
Group therapy

Other ____

2. Please describe some of the feelings or thoughts you or your child is experiencing. (You may check more than one.)

Anger	Depression	Anxiety/Panic
Alcohol/Drugs	Fears	Crying all the time
Acting out in school	Learning problems	Confusion
Relationship issues	Life adjustment/Enhancement	

Other ______________________________

3. How long have you or your child been feeling this way?

Less than 1 week	1-2 weeks	6 weeks
3 months	Less than 6 months	Less than 1 year
More than 1 year		

4. Has anything happened recently or changed in your or your child's life that might be related to these feelings? (You may check more than one.)

Recent loss or death of close friend/family member

Change or loss in work or living situation

Other (please specify) ______________________________

5. Have you or your child felt this way in the past? No Yes If so, when?

Childhood (0-12) Adolescence (13-19) Young adult (20-30)

Other___________

Please explain ______________________________

____

____

6. What do you do for a living (if a minor child, parent/guardian's occupation)?

Full-time employed (specify) ______________________________

Part-time employed (specify) ______________________________

Student Unemployed Other (specify) ______________________________

7. What is your current living situation?

Roommate(s) Spouse/partner Children Parents Single/alone

8. Are you currently in a relationship? No Yes If so, for how long? ___________

9. Do you have any children? Yes If yes, how many? ______ No

10. Have you or your child had counseling before? If so, did it help?

Yes ____ No

11. Have you or your child ever been in a drug or alcohol treatment program?

If so, when? Yes ____ No

12. Have you or your child ever been hospitalized for psychological reasons (i.e. for depression)? If yes, for what reason? When did this occur?

Yes ____ No

13. Are you or your child(ren) currently taking any medications, such as for anxiety, depression, ADHD, etc.? If so, please list names and dosages.

Yes ____ No

14. Have you or your child(ren) ever been charged or convicted of a crime (misdemeanor or felony)?

Yes ____ No

15. How many alcoholic drinks do you or your child (ren) have in a typical week?

Please check amount:

0-3 4-7 8-11 12-15 More than 15

16. What is your (or your child's/ren's) racial or ethnic background?

Asian-American African-American Hispanic Caucasian Other

Date of birth: **Highest grade/degree completed:**

Please check "Yes" or "No" for the following questions.

17. Do you use any street drugs or medications prescribed for someone else?

Yes No

18. Are you ever involved in physical fights with other people?

Yes No

19. Are you currently, or have you ever been, involved in the legal system?

Yes No

20. Has your family ever been involved with Child Protective Service?

Yes No

21. If you have children, have you ever lost custody of your children?

Yes No

Thank you for taking the time to fill out our application. Please sign, date, and return the Intake Application to the LifeStyle Assistant or LifeStyle Professional.

Client Signature ____________________ Date ____________________

Guardian Signature (if applicable) ____________________ Date ____________________

LifeStyle Consultant/Representative ____________________ Date ____________________

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