Dominion Center for Behavioral Health Services, PC

PARENT COACHING INTAKE FORM

Parent #1 Name:_____ **Date:**_____

Parent #2 Name: _____

Parent #1:

Address:_____ **Sex: □ Male □ Female**

_____ **Date of Birth:**_____

_____ **Age:**_____

Home Phone:_____ **Work Phone:**_____

Cell Phone:_____ **E-Mail Address:**_____

Is there any number at which you do not wish to be contacted? If so, specify:

_____

Do you regularly attend a church, synagogue, or other religious institution? If so, specify: _____

What is your current occupation?_____ **Level of Satisfaction?**_____

Parent #2:

Address:_____ **Sex: □ Male □ Female**

_____ **Date of Birth:**_____

_____ **Age:**_____

Home Phone:_____ **Work Phone:**_____

Cell Phone:_____ **E-Mail Address:**_____

Is there any number at which you do not wish to be contacted? If so, specify:

_____

Do you regularly attend a church, synagogue, or other religious institution? If so, specify: _____

What is your current occupation?_____ **Level of Satisfaction?**_____

RELATIONAL INFORMATION:

Parent #1 Current Marital Status:

□ Single □ Engaged □ Married □ Separated □ Divorced □ Widowed

If engaged, married, separated, divorced or widowed, for how long?_____

Spouse's name_____ Age:_____

Is your spouse supportive of you seeking coaching? □ Yes □ No □ Unsure

□ Spouse doesn't know Number of previous marriages for you_____

Parent #2 Current Marital Status:

□ Single □ Engaged □ Married □ Separated □ Divorced □ Widowed

If engaged, married, separated, divorced or widowed, for how long?_____

Spouse's name_____ Age:_____

Is your spouse supportive of you seeking coaching? □ Yes □ No □ Unsure

□ Spouse doesn't know Number of previous marriages for you_____

Please list your children (including step, adopted, foster) below:				
Child's Name	**Sex**	**Age (or year of death)**	**Relationship to you**	**Living with Whom?**

Who else lives with you?_____

COUNSELING HISTORY:

If you or your child have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the names of the therapies or programs. Use the back, if necessary.

Therapist's Name or Program	**Major Issue**	**Dates**

Has anyone in your family ever been treated or hospitalized for substance abuse, mental health issues, or psychiatric conditions? □ Yes □ No

If yes, please describe:_____

Has any family member ever attempted or committed suicide? □ Yes □ No

If yes, who and when:_____

MEDICAL HISTORY:

Please list any conditions, illnesses, treatments, or surgeries that might be relevant to your reason for seeking coaching:_____

_____

Are you or your child(ren) currently receiving any medical treatment?

□ Yes □ No If yes, please describe:_____

Please list all current medications you or your child(ren) are taking and the reasons for taking them. List even if you seldom use, or take only as needed.		
Name of Medication	**Dose**	**Reason for Taking**

Are you taking these medications according to doctor's recommendations?

□ Yes □ No If no, please explain:_____

Date and outcome of your or your child's last physical exam:_____

_____

PRESENT ISSUES AND GOALS:

Please describe your overall goals as a parent: _____

_____

When was the last time you felt good about your parenting and/or relationship with your child(ren)? _____

_____

What are your biggest challenges as a parent? _____

_____

What do you see as the most important role/responsibility of a parent? _____

_____

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What questions would you like to see addressed by your parenting coach?

_____

_____

Check any of the following symptoms or problems that you currently are or recently have experienced:

	In yourself		In your child(ren)		In your household
	Stress		Disobedience		Anger
	Anxiety		Disrespect		Aggressive Behavior
	Panic		Sibling Fights		Physical Abuse
	Depression		Unwillingness to do Chores		Emotional Abuse
	Marital Problems		Inattention		Verbal Abuse
	Fatigue/Lack of Energy		Tantrums		Sexual Abuse
	Loss of Appetite/Overeating		Homework Issues		Sexual Problems
	Trouble Sleeping		Poor Grades		Financial Problems
	Obsessive Thoughts		Urination/Defecation Problems		Legal Problems
	Low Self-Esteem		Bedtime Difficulties		Extreme Tension
	Impatience		Eating Problems		Work Stress/Job Loss
	Grief		Dishonesty		Drug Use
	Chronic Pain		Trouble with Friends		Alcohol Use
	Loneliness		Discipline Problems in School		Recent Death
	Fears		Seeks Negative Attention		Impulsive Behavior
	Feeling Out of Control		Excessive Worry		Controlling Behavior
	Poor Health		Fearfulness		Isolation

Please use an "X" on the scale below to indicate how distressing your problem(s) are to you.

[----------]

Minimally Distressed **Moderately Distressed** **Extremely Distressed**

Are you currently experiencing suicidal thoughts? □ Yes □ No

Have you experienced suicidal thoughts in the past? □ Yes □ No

Have you attempted suicide in the past? □ Yes □ No

Are you currently experiencing any violent/homicidal thoughts? □ Yes □ No

What do you hope to gain from this coaching experience?_____

_____

_____

_____ _____

Client's Signature **Date**