CAROL UMMEL LINDQUIST, PH.D., FACLINP
CLINICAL PSYCHOLOGIST

THE PSYCHOLOGY CENTER
380 GLENNEYRE SUITE D
LAGUNA BEACH, CA 92651

Coaching Client Information

Full Name: _____
first middle last

Address: _____
street city state zip

Home Phone:( )_____Work Phone: ( )_____ Cell Phone: ( )_____
Please circle preferred phone above for messages. As a courtesy, we notify you of next day's appointment.
Please check here if you do not want to be reminded: ___

Birthdate: _____ Age: _____ Social Security #: _____

Occupation/Job Title: _____ Employer: _____

Employment.Address: _____

Length of time on job: _____ Email: _____

Spouse/Partner Information

Name:_____ Years Married: _____

Birthdate: _____ Age: _____ Social Security #: _____

Occupation/Job Title:_____ Employer: _____

Employment Address: _____

_____

Name of Referral: Date: _____

(May we contact them to thank them) (Yes) (No) Phone #: _____

Person To Notify In Case of Emergency (Other Than Spouse)

Name: _____Relationship to You: _____

Address: _____ Phone: ( )_____

Coaching Goals:

Briefly describe or list your goals for Coaching: _____

_____

Current Symptoms/Problem and Background Information

Briefly describe reason for seeking help: _____

Approximate date these problems/symptoms first appeared: _____

Have you ever had these problems/symptoms before? Yes No If Yes, when? _____

Approximate date of last physical examination/visit to your (name of) M.D.? _____

For what reason(s)? _____

List current health problems: _____

List names and telephone numbers of Physicians concurrently treating you and indicate if we may contact them should the need arise:_____

List the members of your family and all others living with you at this time:

Name	Age	Relationship	Occupation

Prior History of Psychological/Psychiatric Treatment or Treatment for Alcohol or Drug Problems

Dates Problem Outpt/Inpt Name of MD/Therapist (Phone if known)

_____

_____

_____

If you drink alcoholic beverages, please indicate which kind and how often:

_____

If you use drugs of any kind, including prescription medications and/or street drugs, please indicate which kind, for what purpose, the dosage/amount and frequency:

Drugs (marijuana, cocaine, ecstasy, prescription) Purpose Dosage/Frequency

_____

_____

_____

Have you seen a Chiropractor, Physical Therapist, or Alternative Healer? _____

Name & how recently_____

Names and relationship to you of family members in which there has been a drinking or drug problem (include grandparents, aunts or uncles):

_____

_____

_____

Have you or has anyone in your family had an eating problem (e.g. overeating, anorexia, bulimia)?

Yes No If yes, who? _____

Have you been a victim of physical, sexual or emotional abuse or neglect? Yes No
If yes, by whom?
_____

Do you currently have any legal problems? Yes No If yes, please describe:

_____

_____

Symptom Checklist

Please circle any of the following problems that apply to you: Number the most important.

Nervousness	Depression	Fears	Shyness
Sexual Problems	Suicidal Thoughts	Separation	Divorce
Finances	Drug Use	Alcohol Use	Friends
Anger	Self Control	Unhappiness	Sleep
Stress	Work	Relaxation	Headaches
Tiredness	Legal Matters	Memory	Ambition
Energy	Insomnia	Making Decisions	Loneliness
Concentration	Health Problems	School	Career Choices
Marriage Problems	Temper	Nightmares	Appetite
Stomach Trouble	Bowel Troubles	Being a Parent	My thoughts
Children	Inferiority Feelings	My parents	Education
Self Confidence	Anxiety	Aging	Guilt
Menopause Issues			

List parents, step-parents, siblings and any children of yours and/or your spouse who do not live with you:

Name	Age	Relationship	Occupation

Thank you for your time and attention in completing this information form. Rev. 4/09