

Possibility Coaching

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Intake Questionnaire

In order to help identify the most effective strategy for helping you work toward your goal, I'll need some information. Please be as thorough as you can. If you have any questions, please ask me when we meet.

Your Name: _____ Age: _____ Date: _____

Address: _____ City, State: _____ Zip code: _____

1. What is the challenge you are facing which caused you to seek some coaching and support?

2. What are your hopes for the future?

3. Is there a particular reason you are seeking an appointment now?

4. Have you ever been to a counselor or life coach before ? ☐ Yes ☐ No

What was that like for you?

5. What is your hope about what you will get out of the work we will do together?:

6. Have you been to the doctor in the past year? ☐ Yes ☐ No (If yes, date: _____)

7. How is your current health? Are you being treated for anything?

8. What medical or physical concerns do you have??

Comments:

9. Do you experience headaches? ☐ Yes ☐ No

If yes, please describe the type, frequency and severity:

10. Are you taking medication, either prescription or over-the-counter?

☐ Yes ☐ No

If yes, carefully list the specific medication and dose date prescribed, who prescribed, and what for

Medication	Amount Prescribed	Frequency (1x, 2x)	Prescribed by:	Reason for prescription

11. Have you ever taken medication for attention, behavior or mood in the past? ☐ Yes ☐ No

If yes, what did you take, for how long, and what was your experience?

12. Are you allergic to anything including medications? ☐ Yes ☐ No If yes, please describe:

13. Do you use tobacco? ☐ Yes ☐ No If yes, describe frequency/amount

14. How much coffee or other caffeinated beverages, sodas, or sports drinks do you consume?

15. How much alcohol do you consume during a typical week day? Week end?

16. What recreational drugs do you use?

17. Please check any of the following sleep problems that you experience:

<input type="checkbox"/> Difficulty waking in the morning		<input type="checkbox"/> Difficulty falling asleep
<input type="checkbox"/> Not rested after sleep		<input type="checkbox"/> Physically restless sleep
<input type="checkbox"/> Sleeping too much		<input type="checkbox"/> Nightmares or bad dreams
<input type="checkbox"/> Snoring		<input type="checkbox"/> Teeth grinding
<input type="checkbox"/> Sleep apnea (stops breathing)		<input type="checkbox"/> Restless leg
<input type="checkbox"/> Bed wetting		<input type="checkbox"/> Difficulty staying asleep

18. Anything else it would be helpful to know about?

On a scale of 1 – 10, with 1 being very bad to 10 being very good, how have you felt over the past week in the following areas:

Health

1 2 3 4 5 6 7 8 9 10

Emotional Well-being

1 2 3 4 5 6 7 8 9 10

Energy level

1 2 3 4 5 6 7 8 9 10

Feelings about self

1 2 3 4 5 6 7 8 9 10

Feelings about others

1 2 3 4 5 6 7 8 9 10

19. Is there anything else you would like me to know?

Thank you!