

**COACHING AND COUNSELING CLIENT HISTORY**

**WITH DR. BETTY LUE LIEBER, PHD. MFT #12760**

Date: \_\_\_\_\_

*To serve you with excellence, I need to know you better.*

*Please fill in this form thoroughly or tell me what will aid me in supporting you best.*

**Name** \_\_\_\_\_

**Email** \_\_\_\_\_

**Address** \_\_\_\_\_

**Phone(s)** home \_\_\_\_\_ work \_\_\_\_\_ cell \_\_\_\_\_

**Birthdate** \_\_\_\_\_  Married  Single  Divorced  Separated

**Children** (names and ages) \_\_\_\_\_

**Current Employment** company \_\_\_\_\_

address \_\_\_\_\_

duties \_\_\_\_\_

Do you have any language or cultural concerns? \_\_\_\_\_

What are your reasons for making this appointment? \_\_\_\_\_

What are the goals you would like to accomplish with our work together?

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

Currently, what are your major areas of dissatisfaction in your life? \_\_\_\_\_

Current state of health: \_\_\_\_\_

List current or previous Trauma, Illness, Injury, Surgery, and approximate dates or ages:

Current Medications/supplements: \_\_\_\_\_

**(Please complete the other side)**

## CREATIVE SOLUTIONS COACHING AND COUNSELING SURVEY

Your honest answers will assist our work together greatly.

Which of the following areas would you consider to be **Problem Areas** for you?

|                      |       |                           |       |
|----------------------|-------|---------------------------|-------|
| Current Stress level | _____ | Children                  | _____ |
| Health               | _____ | Marriage / Relationship   | _____ |
| Body                 | _____ | Self-confidence           | _____ |
| Exercise             | _____ | Communication             | _____ |
| Diet / Food          | _____ | Life purpose              | _____ |
| Recreation / play    | _____ | Expressing feelings       | _____ |
| Work / career        | _____ | Your home                 | _____ |
| Rest & relaxation    | _____ | Order in everyday affairs | _____ |
| Finances             | _____ | Making changes            | _____ |
| Friends              | _____ | Decision making           | _____ |
| Sexuality            | _____ | Success in Life           | _____ |
| Drug usage           | _____ | Your future & goals       | _____ |
| Parents              | _____ | Spirituality              | _____ |

Are you involved in any ongoing substance treatment or recovery program? Yes / No

What? \_\_\_\_\_

Do you have **any other problem** areas that cause stress, fear or upset?

---

**“I voluntarily agree to participate in counseling.”**

Client Signature: \_\_\_\_\_

**For insurance clients, we need the following information:**

**Insurance Coverage:** \_\_MediCal \_\_EAP \_\_Other \_\_Out of Network \$\_\_\_\_\_Deductible

**Plan Name:** \_\_\_\_\_ **Plan Phone** \_\_\_\_\_ **Insurance ID#** \_\_\_\_\_

**Sessions Authorized:** #\_\_\_\_\_ Start \_\_\_\_\_ Expires \_\_\_\_\_ Auth # \_\_\_\_\_ Contract Rate: \$\_\_\_\_\_

**Insurance Billing Address:** \_\_\_\_\_

**Please sign, if using your insurance or employee assistance program:**

**“I authorize the release of any information necessary (including notes, treatment summaries and diagnosis) to my insurance plan or EAP to process claims, determine medical necessity, or to request additional sessions.”**

Client Signature: \_\_\_\_\_

**“I authorize payment of benefits to my provider.”**

Client Signature: \_\_\_\_\_