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 _____

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. _____
5. _____

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 Medication/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	_____

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

_____

_____

_____

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: _____