Electronic Form Submission Instructions

Please complete and submit this form electronically by email to: justine@mindquestgroup.com or to the email address supplied by a designated Mindquest Group representative.
Do NOT print and scan or return a hard copy. Please do NOT use EchoSign to sign this form.

This form should be opened with **Adobe Reader**. If you do not have Adobe Reader on your computer, you may download it for free here:

PC: http://get.adobe.com/reader/

Mac: http://www.adobe.com/support/downloads/detail.jsp?ftpID=5718

Mindquest Support Services
Intake Form – Adult

Name of Client			Gender
Preferred Name			
Age		Birthdate	
Cultural Background		Nationality	
Relationship Status		Religion	
Profession		Employer	
Favorite Leisure Activity			
Primary Language		Secondary Language	
Address			
Email for Correspondence			
Note: Please provide an email address for communication relating to your coaching or counseling services. This may be an alternate to your regular business address.			
Home Phone		Mobile Phone	
Work Phone		Which number do you prefer to be contacted via?	

Please make sure that all information given below is correct.

Last Medical Examination		Reason	
Are You under a Doctor's Care?		If yes, Doctor's name	
Reason for Doctor's Care			
Are You Taking Any Medication?		If yes, what kind?	
Reason for Medication			
Have You Ever Been Hospitalized for a Physical Illness?			
Describe			
Have You Even Been Hospitalized for a Mental Illness, Personality Disorder, Anxiety Disorder, etc?			
Describe			
Do you suffer from epilepsy?		If so, please provide further details below:	
Any Previous Therapy/Counselling?		If Yes, Name and Phone Numbers of Therapists:	
When and Number of Sessions?			
Type of Therapy/Counselling			
Please indicate if you would like us to follow up with previous specialists consulted.			
How were you referred you to Mindquest Group?			

What Are Your 3 Strongest Points?
What Are Your 3 Weakest Points?
When Are You Happiest?
What Makes You Worry or Uncomfortable?
What Makes You Angry?

Check Any of the Following That May Apply to You:

☐	Headache	☐	Inferiority Feelings	☐	Shy With People
☐	Dizziness	☐	Feel Tense	☐	Can't Make Friends
☐	Fainting Spells	☐	Feel Panicky	☐	Afraid Of People
☐	No Appetite	☐	Fears and Phobias	☐	Can't Keep a Friend
☐	Over-Eating	☐	Obsessions	☐	Home Conditions Bad
☐	Stomach Trouble	☐	Depressed	☐	Unable To Have A Good Time
☐	Bowel Disturbances	☐	Suicidal Ideas	☐	Always Worried About Something
☐	Always Tired	☐	Drugs	☐	Don't Like Weekends/Vacations
☐	Always Sleepy	☐	Skin Problems	☐	Can't Make Decisions
☐	Unable To Relax	☐	Low Self-Esteem	☐	Difficulty controlling anger
☐	Insomnia	☐	Allergy	☐	Relationship difficulties
☐	Recurrent Dreams	☐	Asthma	☐	Infidelity
☐	Nightmares	☐	Homosexuality	☐	Alcohol
☐	Hallucinations	☐	Difficulties with Work	☐	Other

In case of emergency:

Person to contact:			Relationship		
Address					
Home Phone		Office Phone		Mobile	
Email					

I give permission for my coach/counsellor to contact the above named person in the event of an emergency. All information provided in this form is confidential and is used strictly for the purposes of my coach/counsellor, in supporting me through the coaching or counselling process. I understand that Justine Campbell and specialists operating under Mindquest Group undertake regular peer supervision and may at times discuss my case in order to maintain her high professional standards in delivering coaching or counseling services to their clients. I confirm that the information contained in this form is accurate to the best of my knowledge.

_____	_____	_____
Name of Client	Signature of Client	Today's Date