iACTcenter

Client Profile

Full Name: _____ **Start Date:** _____**End Date:**_____
Email: _____ Phone:_____
Consult Date: _____ Strategy Session Date: _____ Time Zone:_____
Who Referred You? _____ Location: _____
Support_____Birthday:_____

What is it that you need to take away from this meeting? What is the main challenge you are facing?

_____
_____
_____
_____
_____

Personal Information:
School/Grade: _____Siblings Names: _____
Relationship Status: _____ S.O. Name: _____
Children's Names: _____

Personal Growth:
VIA Character Strengths: 1. _____ 2. _____ 3. _____
4._____ 5._____ 6._____
Learning Styles: _____
Spiritual Gifting: _____
Love Languages: _____
Core Values: 1. _____ 2. _____ 3. _____ 4._____
5. _____ 6. _____ 7. _____

Brief Physical History:
Dr:_____ **Psychiatrist/Psychologist/Therapist:**
Date and method of Diagnosis: _____
Current Medication/dose: _____ Past meds_____
Caffeine: _____ Cig: _____ Alcohol/Marijuana: _____
Exercise: _____Menopause: _____Sleep: _____
Diet:_____Alternative(vitamins, herbal, acupuncture_____

Initial Coaching Goals:
1. _____ 2. _____ 3. _____