Dragonfly Counseling
8905 Regents Park Drive, Suite 230
Tampa, FL 33647 (813) 541-6619

Initial Client Intake And Screening Instrument

First Name: Last Name:

Street Address: City: State: Zip:

Home Phone: Cell Phone: E-Mail:

Primary Contact #: ◯ Home ◯ Cell May I Leave a Message? ◯ Yes ◯ No

Age: Date of Birth Sex: ◯ M ◯ F Race

Marital Status: If Single, are you in a Relationship? ◯ Yes ◯ No

Living With: Number of Children: Ages:

Occupation: Employer: For How Long?

Are you Happy at Work? ◯ Yes ◯ No

What other stressful issues are you currently dealing with?

Why do you want to lose weight?

I think my weight problem is due to:

I would like to lose approximately pounds.

Approximate current weight: Height:

At what age were you first overweight?

At what age did you first try to lose weight?

Have you ever been successful at any attempt to lose weight? ◯ Yes ◯ No

Describe prior attempts:

Have you ever been in counseling or worked with any other mental health provider?

Describe:

List any health problems you have:

List any medications you are taking:

Do you have any learning disabilities? ◯ Yes ◯ No

Describe:

Imagine that you are successful and are at the weight that you'd like to be. How would your life be different? What are the main benefits of losing weight for you?

Is there anything else you would like to change in your life or in yourself?

What would you want to make sure I understand about you in order to make sure I know you? (If this is something that you only want to discuss in person, just write, "When we talk.")