CLIENT INTAKE FORM

Name _____ Date _____

Address _____ Emergency contact _____ Phone _____

Phone _____ Case worker _____

**Please answer the questions below.

Do you plan on moving out ? ☐ Yes ☐ No

How did you learn about us? _____

Have you received ILS before? ☐ Yes ☐ No

Are you on any medication? ☐ Yes ☐ No If yes, which ones _____

Do you exercise? ☐ Yes ☐ No If yes, how many times per week ? ____ How many hours? ____

**Please mark any of the following conditions or allergies you may currently have.

- ☐ Food allergy
- ☐ Animals
- ☐ Emotional changes
- ☐ Insects
- ☐ Medicines
- ☐ Cold virus
- ☐ Trees/grass
- ☐ Alcohol within 24hrs
- ☐ Kidney alignment
- ☐ Sports injury
- ☐ Phlebitis
- ☐ Bruises
- ☐ High Blood pressure
- ☐ Varicose veins
- ☐ Acute pain
- ☐ Grief process
- ☐ Recent surgery
- ☐ Open wounds
- ☐ Osteoporosis
- ☐ Chronic pains
- ☐ Blood clot
- ☐ Fever within 24hrs
- ☐ Wear contacts
- ☐ Others, please specify _____

Tell us what you need assistance with

GOALS

FOR EACH OF THE CATEGORIES BELOW, WRITE DOWN THINGS YOU ARE DOING WELL AND WHERE YOU NEED IMPROVEMENT. TAKE THE TIME TO REFLECT ON THESE, AND WRITE A GOAL FOR EACH CATEGORY.

CATEGORY	WHAT I'M DOING WELL	WHERE I NEED IMPROVEMENT	MY GOALS
CARRER/ EDUCATION			
FRIENDS OR FAMILY			
WORK/ SCHOOL			
BODY			
MENTAL HEALTH			
SPIRITUALITY			

GOALS

FOR EACH OF THE CATEGORIES BELOW, WRITE DOWN THINGS YOU ARE DOING WELL AND WHERE YOU NEED IMPROVEMENT. TAKE THE TIME TO REFLECT ON THESE, AND WRITE A GOAL FOR EACH CATEGORY.

CATEGORY	WHAT I'M DOING WELL	WHERE I NEED IMPROVEMENT	MY GOALS
HOUSEHOLD TASK			
MEAL PLANNING			
BUDGETING			

Signature _____