

**Welcome To Life Coaching**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number (s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As your Life Coach, it is important for me to get to know what it is that you *really* want out of life.

Please answer each of the following questions as clearly and thoughtfully as possible, expressing the best of who you are NOW. These are ‘pondering’ questions designed to stimulate your thinking in a particular way that will make our work together even more productive. I suggest that you take several days to compose your responses to these questions. Thank-you and have fun!

1) What do you hope to achieve through our sessions together? Why did you want to come and see me? What is your intention of working together? This is something we will come back to often.

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2) What difference would working with a Life Coach make for your life?

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3) In order to get the most out of our sessions what tips would you give me about working with you?

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4) Can you predict what others would say about you if they were asked to describe you? Do you like what they’d say? Why or why not?

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5) What accomplishment must occur during your lifetime in order for you to live a life of few or no regrets?

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6) What is missing in your life? What would make your life more fulfilling?

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7) In 30 seconds or less write down the 3 most important goals in your life right now.

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8) What would you do if you only had six months to live?

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9) What do you never procrastinate? What do you love doing?

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10) What things would you dare to dream if you know you could not fail, if there were no restrictions at all (ie. Time, money)? What have you always wanted to do but have been afraid to attempt?

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11) Looking back at all the things that you have done, what gave you the greatest feeling of importance?

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12) Describe how you feel when you wake up in the morning and before you go to bed at night.

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13) Do you love, respect and appreciate yourself? Why or why not?

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14) Do you love, respect and appreciate your body? Why or why not?

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15) Please describe your current relationship with food.

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16) Please describe your current home environment i.e. Do you live on your own? With others? If so who? What state is your home in? Do you like your home life and surroundings?

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17) Is it easy for you to make decisions about how to spend your time? Please explain.

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18) What are your main priorities in your life today? Have these always been your priorities? Please explain where most of your focus is and where it used to be.

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19) If I was a fairy godmother and could grant you ANYTHING that you wanted for yourself and your life what would your life look like? How would it be different then it is today?

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20) What are the things you want to work on over our time together? Please prioritize them, so we both have an idea for which ones to focus on first. If you are unsure, don’t worry, we will figure this all out in our sessions together.

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Before starting our work together, I would like you to purchase a journal. We will be using this during our first session. Make sure you love looking at the journal and it makes you smile as this is going to be a very important tool for our work together.

I look forward to working with you!

 Paula

INFORMED CONSENT – Life Coaching, Counseling Therapy, Generational Healing TM & Shamanic Services

TO THE Client: You have the right, as a client, to be informed about therapy treatments of Counseling Therapy, Coaching and Generational Healing, so as make an informed decision whether or not to undergo the recommended treatment modalities after knowing the benefits and or risks involved. This document is not meant to alarm you; it is simply to inform you that you may give or withhold your consent to Therapy. I have agreed to the terms outlined:

*If you refuse any future therapy this will not affect your receiving other care or future treatments in the Clinic.*

* I **voluntarily accept** Paula Galli, B.Sc, CNP or Angela Croft, MSW, RSW to provide services: Counseling Therapy, Life Coaching, Generational Healing TM or Shamanic Treatments in my best interest, to better my health condition.
* I understand that anything I discuss in the above services with Paula Galli or Angela Croft is strictly confidential.
* I also understand that I must give express written or verbal permission to Paula Galli or Angela Croft to share any aspect of our work together that would identify me specifically and breach confidentiality.
* The only exceptions to confidentiality are in such cases where the issue of potential harm to myself and/or others is disclosed. I acknowledge that in such cases my own safety and/or the safety of others takes priority if the appropriate authorities need to be notified without my consent.
* By signing below I acknowledge that the limits of confidentiality have been explained in full to me, that any questions I have pertaining to the limits of confidentiality have been addressed, and that I am free at any time to request further clarification.
* I understand that there may be some health benefits and risks with Counseling Therapy, Life Coaching, Generational Healing TM or Shamanic Treatments.
* I understand that I have the right and the opportunity to ask questions about my condition, discuss further therapy sessions, or any other therapy modalities at any given time.
* I may request additional information regarding the above services.
* I may cancel the appointment up to 24 hours prior to a scheduled session. A missed appointment will mean a missed session and it will not be refunded. (A business day is defined at Monday to Friday, excluding Holidays).
* I understand that all the plans/programs purchased are non-refundable and that the payment must be made before the first session of any of the plans purchased.
* I agree to allow my contact information be exchanged with the other medical professionals within Visionary Health or Team of Care under the guidelines/ jurisprudence of the College and/or institute in relation to the above services.
* Payment of services will be expected, based on the fee schedule.
* If any additional telephone, electronic, email or online services apply, I will be informed, and fees could be incurred.
* I further understand that any insurance reimbursement will be my responsibility until I authorize for direct billing to my insurance provider.
* Appointments will ordinarily be 60-90 minutes in duration, unless we agree to additional time and charges.
* In an emergency situation, I understand that I should not solely rely on reaching the practitioner and if there are any indications of an emergency, I am to go to my local hospital, contact the police department or dial 911.
* I understand that no warranty or guarantee regarding a promise of cure as a result of care is provided for any condition.
* I understand that a record will be kept of the health services provided to me and will be kept confidential.
* I give consent and authorize Visionary Health Educational and Medical Clinic practitioner to contact me in the near future for continued treatment.
* I authorize Visionary Health Educational Medical Clinic to make contact to inform me of educational events, promotions, incentives, newsletters, and of any health benefits.
* I certify that I have read this form or have had it read to me, and that I understand its contents and meaning. I have sufficient information to give this informed consent.
* If the client is a minor under 18years of age, I the undersigned, take full responsibility and acknowledge agreement to the above statements and act on their behalf.
* I am consenting to a virtual session or an in person clinic and agree to above.

Patient Name Patient Signature Date

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Witness Name/Signature Date

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