



Abundant Life Counseling St. Louis LLC

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Client Information

Date: _____

NAME: _____ NICKNAME: _____

Date of Birth: ____/____/____ Gender: Female Male Transgender Decline to Answer

Address: _____ City _____ State _____ Zip _____

Phone (home): _____ (Cell) _____ (Work) _____

Email address: _____

Race: Caucasian African American Hispanic Asian American Other: _____

Marital Status: Married (_____ mos/years)
 Living Together Without Marriage (_____ mos/years)
 Never Married
 Widowed (_____ mos/years)
 Engaged
 Divorced/Separated (_____ mos/years)

Religion/Church Affiliation: Jewish Catholic Protestant None Other: _____

Primary Place of Worship/Church Home: _____

Primary Physician: _____ Phone: _____

Date of last physical exam: _____

Psychiatrist: _____ Phone: _____

Highest Education Level: _____

Military Service Branch: _____ Dates of Service: _____ Highest Rank: _____

Occupation: _____

Employer: _____ Part-Time Full-Time

PARTNER/SPOUSE:

Partner/Spouse's Name: _____

Preferred Phone Number: _____ Home Work Mobile Other: _____

Address: (Same as above) _____

IN CASE OF EMERGENCY CONTACT:

Name: _____ Preferred Number: _____

CHILDREN:

Name	DOB	Gender	Grade Level and/or Occupation
_____	__/__/__	___	_____
_____	__/__/__	___	_____
_____	__/__/__	___	_____
_____	__/__/__	___	_____

OTHERS IN THE HOME:

Name	DOB	Gender	Grade Level and/or Occupation	Relation
_____	__/__/__	___	_____	_____
_____	__/__/__	___	_____	_____
_____	__/__/__	___	_____	_____
_____	__/__/__	___	_____	_____

TOTAL NUMBER IN HOUSEHOLD: _____

How did you hear about Abundant Life Counseling St. Louis and/or Julie Williamson, LPC, RPT?

May I send this person/organization a thank-you note for referring you? Yes No

What Are Your Current Concerns?: _____

Why Have You Sought Treatment Now?: _____

What Are Your Expectations For Treatment?: _____

Have you previously sought counseling for these and/or other concerns? Yes No

Therapist _____ Profession _____ Dates: _____

Therapist _____ Profession _____ Dates: _____

How satisfactory was your experience(s)? _____

Are you presently working with any other Counselor or Psychologist? Yes No

For what reason? _____ Therapist: _____

Are you involved in any other counseling or support group?

No

Yes - Group Name: _____ Leader: _____

Do you currently have thoughts of harming yourself or someone else? Yes No

MENTAL HEALTH HISTORY: Have you or a family member ever experienced or been diagnosed with the following?

	Self	Family Member	This Person's Relation to You?
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Suicidal Thoughts/Actions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bipolar Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Alzheimer's	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Paranoia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Learning Difficulties	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Attention Difficulties	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hallucinations/Delusions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Eating Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Behavior Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sleep Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Alcohol Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other Addictions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Physical Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sexual Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Self-Harming Behavior	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Witness or Been the Victim of Domestic Violence	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Any other mental health concerns you would like to mention? _____

Please describe any sleep disturbances: _____

Have you ever been hospitalized for mental illness or substance abuse? Yes No

If yes, for what reason? _____

Dates of Treatment: _____

Treatment Center/Hospital Name: _____

Did you continue with outpatient counseling? Yes No

Name of Counselor: _____

Have you previously met with a psychiatrist? Yes (please complete table below) No

Psychiatrist's Name	Diagnoses Given	Dates of Treatment

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SUBSTANCE ABUSE/DEPENDENCE:

Have you ever used the following substances:

	Current	Substance	Date of Last Use:
Depressants (e.g. alcohol)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Stimulants (e.g. cocaine)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Narcotics (e.g. Demerol)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Hallucinogens (e.g. PCP)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Cannabinoids (e.g. marijuana)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other Substances:	<input type="checkbox"/> Yes <input type="checkbox"/> No		

CURRENT ENVIRONMENTAL STRESSORS:

Recent or Significant Death	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relation(s) to Self: Date:
Significant Moves:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date(s): Location(s):
Child Medical Problems:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please Explain:
Family Medical Problems:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please Explain:
Financial Problems:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please Explain:
Safety of Yourself and/or Others:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please Explain:

Other Stressors: _____

PHYSICAL HEALTH & MEDICAL HISTORY:

Physical Health Status: Excellent Good Fair Poor

Please list previous medical doctors, diagnoses, and dates of treatment:

Current medications: N/A Yes:

_____ Dose _____

_____ Dose _____

_____ Dose _____

Have you ever experienced the following:

Head Injury? No Yes (please explain with dates: _____)

Concussion? No Yes (please explain with dates: _____)

Seizure? No Yes (please explain with dates: _____)

Serious Accident? No Yes (please explain with dates: _____)

Major Surgery? No Yes (please explain with dates: _____)

Medical Hospitalizations? No Yes (please explain with dates: _____)

Medical Problems (Check all that apply):

- | | | | | |
|--|--|--|---|--|
| <input type="checkbox"/> AIDS/HIV+ | <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Gout | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Peptic Ulcer |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Crohn's/Colitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lupus | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Herpes | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Headaches | <input type="checkbox"/> Migraine | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hyperthyroid | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Obesity | <input type="checkbox"/> Urinary Tract |

Other Medical Problems (specify): _____

LEGAL HISTORY

Present Charges: Yes No

Past Charges: Yes No

Please list charge & date:

Please list charge & date:

Any other current legal concerns? _____

Is there any other information you would like to share? _____
