Abundant Life Counseling St. Louis LLC

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Client Information

Date: _____

NAME: _____ NICKNAME:_____

Date of Birth: _____/_____/_____ Gender: ☐ Female ☐ Male

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) _____

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_____ Dates: _____

Therapist_____ 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	☐ Yes ☐No	☐ Yes ☐No	
Anxiety	☐ Yes ☐No	☐ Yes ☐No	
Suicidal Thoughts/Actions	☐ Yes ☐No	☐ Yes ☐No	
Bipolar Disorder	☐ Yes ☐No	☐ Yes ☐No	
Alzheimer's	☐ Yes ☐No	☐ Yes ☐No	
Paranoia	☐ Yes ☐No	☐ Yes ☐No	
Learning Difficulties	☐ Yes ☐No	☐ Yes ☐No	
Attention Difficulties	☐ Yes ☐No	☐ Yes ☐No	
Hallucinations/Delusions	☐ Yes ☐No	☐ Yes ☐No	
Eating Problems	☐ Yes ☐No	☐ Yes ☐No	
Behavior Problems	☐ Yes ☐No	☐ Yes ☐No	
Sleep Problems	☐ Yes ☐No	☐ Yes ☐No	
Alcohol Addiction	☐ Yes ☐No	☐ Yes ☐No	
Drug Addiction	☐ Yes ☐No	☐ Yes ☐No	
Other Addictions	☐ Yes ☐No	☐ Yes ☐No	
Physical Abuse	☐ Yes ☐No	☐ Yes ☐No	
Sexual Abuse	☐ Yes ☐No	☐ Yes ☐No	
Self-Harming Behavior	☐ Yes ☐No	☐ Yes ☐No	
Witness or Been the Victim of Domestic Violence	☐ Yes ☐No	☐ Yes ☐No	

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

_____

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**

SUBSTANCE ABUSE/DEPENDENCE:
Have you ever used the following substances:

	Current	**Substance**	**Date of Last Use:**
Depressants (e.g. alcohol)	☐ Yes ☐No		
Stimulants (e.g. cocaine)	☐ Yes ☐No		
Narcotics (e.g. Demerol)	☐ Yes ☐No		
Hallucinogens (e.g. PCP)	☐ Yes ☐No		
Cannabinoids (e.g. marijuana)	☐ Yes ☐No		
Other Substances:	☐ Yes ☐No		

CURRENT ENVIRONMENTAL STRESSORS:

Recent or Significant Death	☐ Yes ☐No	Relation(s) to Self: Date:
Significant Moves:	☐ Yes ☐No	Date(s): Location(s):
Child Medical Problems:	☐ Yes ☐No	Please Explain:
Family Medical Problems:	☐ Yes ☐No	Please Explain:
Financial Problems:	☐ Yes ☐No	Please Explain:
Safety of Yourself and/or Others:	☐ Yes ☐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):

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

☐ Other Medical Problems (specify):_____

LEGAL HISTORY

Present Charges: ☐ Yes ☐ No

Please list charge & date:

_____

_____

_____

_____

Past Charges: ☐ Yes ☐ No

Please list charge & date:

_____

_____

_____

_____

Any other current legal concerns? _____

_____

_____