CLIENT INFORMATION

Client Name ____

Primary Address and Zip Code: ____

____

Cell Phone: __________________________________ Home Phone: _______________________________

Email: ____

Gender: ____Female ____Male Date of Birth (mm/dd/yyyy) _____/_____/______

Current Occupation ____

Previous Occupation ____

Current Marital Status: ____Single ___Engaged ___Married ___Divorced ___Re-Married ___Widowed

Emergency Contact: ____ Phone # _______________________

How did you hear about the Life in Abundance ministry? ____

LEGAL HISTORY

Do you have any legal action (ex: current lawsuit, disability hearing, divorce, child custody, etc. - now pending, upcoming or expected) ____

Please specify and give a brief overview ____

____

____

Have you been ordered by the court to obtain counseling ____

Specify by whom and to what purpose ____

____

Do you have any history of Incarcerations, probations, and/or parole ______________________________

Specify ____

____

Date: ______________ Initials: ___________

MARITAL HISTORY

Name of current spouse ____

Number of years married to current spouse ____

How would you describe your current marriage? ____

____

Names and ages of children from current marriage: ____

____

____

Number of years married to previous spouse: ____

How would you describe your previous marriage? ____

____

Please specify whether divorced or widowed in previous marriage: ______________________________

Names and ages of children from previous marriage: _______________________________________

____

Additional marriages and children: ____

____

List any additional people (and their ages) living with you in your household: ______________________

____

SPIRITUAL HISTORY

Do you attend church regularly? ____

If yes, name of church and pastor: ____

What, if any, spiritual practices does your family engage in: __________________________________

How would you describe your relationship with God? ______________________________________

____

Date: ____________ Initials: ___________

SPIRITUAL HISTORY (continued)

If you were to die tonight, do you know for certain that you would go to heaven? ____Yes ____No

Are you open to discussing spiritual matters during counseling? ____Yes ____No

Do you agree to complete a Temperament Analysis (APS) for counseling purposes? ____Yes ____No

MENTAL HEALTH

Have you previously sought counseling? ____

If yes, provide name and phone number of the counselor/therapist and reason for seeking counseling:

____

____

Have you ever been diagnosed with a mental health disorder? ______________________________

Please specify ____

Have you ever been hospitalized for emotional or behavioral concerns? ______________________

Please specify ____

Have you ever experienced an event that you would describe as traumatic? ___________________

Please specify: ____

Have you ever experienced any of the following:

____Neglect/Abandonment ____Verbal/Emotional Abuse ____Physical Abuse ____Sexual Abuse

Have you ever experienced suicidal thoughts? ____

Please specify: ____

Have you ever attempted to harm yourself physically? ____________________________________

Please specify: ____

Why are you seeking counseling at this time? ____

____

____

Date: ____________ Initials: ___________

MENTAL HEALTH (continued)

What have you tried to do about this, if anything? ____

____

____

What do you believe you will gain from seeking counseling? ______________________________________

____

____

Has anyone in your family sought counseling? ____Yes ____No If so, do you know the reason and the outcome? ____

____

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____

Is there any other information that you think the counselor should know? ________________________

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Date: ____________ Initials: ___________

SYMPTOMS CHECKLIST

Please check any of the following symptoms or conditions that you have had or are now experiencing:

Condition	Past	Present	Condition	Past	Present
Mood highs and lows			Insomnia (can't sleep)		
Weight loss or gain			Excessive worries		
Appetite change			Difficulty concentrating		
Drug use			Hearing unseen voices		
Cigarette smoking			Frequent loss of temper		
Tobacco usage			Acting out in violence		
Irritability			Frequent residence changes		
Excessive stress			Frequent employment changes		
Crying spells			Bed wetting past age 6		
Phobias or fears			Fire setting past age 6		
Hallucinations			Blaming others frequently		
Confusions			Lack of sexual desire		
Low self-esteem			Spiritual confusion		
Compulsive behaviors			Thoughts of suicide		
Depression			Inability to comprehend reading		
Extreme nervousness			Inability to comprehend math		
Excessive drinking			Involvement with the occult		
Indecisiveness			Viewing pornography		
Loss of memory			Physical abuse of children		
Fantasizing			Sexual abuse of children		
Sexual abuse from others			Physical abuse of others		
Physical abuse from others			Excessive sexual activity		
Abortion			Drug use/Addiction		
Divorce			Loss of loved one		
Prescribed Antidepressants			Attempted suicide		

Please give a brief explanation, if necessary, to clarify the items you checked above: ________________

____

____

____

Date: _____________ Initials: ___________

PHYSICAL HEALTH

Name and phone number of primary physician: ____

Date of last complete physical exam: ____

Date of last blood panel completed ____

Have you been tested for Vitamin D deficiency or Thyroid issues? ____Yes ____No

Date tested for Vitamin D: _______________________ Results: _________________________________
Date tested for Thyroid: ________________________ Results: _________________________________

Current health problems ____

List any prescription medications you take regularly, along with the reason they have been prescribed:

____

____

____

What, if any, physical disorders do you have? ____

____

Have you suffered any head injuries? (specify)____

Do you have any eating problems? (specify)____

Have you lost or gained significant weight in the past 6 months? (specify)__________________________

____

Do you have any sleeping problems? (specify)____

How many hours of sleep do you get per night? (specify)_______________________________________

Do you feel rested once awake?____

How often and in what way do you engage in sustained physical activity/exercise? (specify)

____

On average, how many servings of alcohol do you consume in a single sitting? _____________________

How often do you smoke cigarettes?____

Date: _____________ Initials: ____________

PHYSICAL HEALTH (continued)

Do you currently, or have you in the past, used illegal drugs or abused prescription drugs? (specify substances and how frequently) ____

____

Have you ever participated in a drug or alcohol program or group? (specify - ex: Alcoholics Anonymous)

____

Have you ever lived with someone who had a drug or alcohol dependency? (specify) _________________

____

Date: ____________ Initials: ___________