LIFE IN ABUNDANCE

Your Life. His Purpose.

CLIENT INFORMATION

Client Name _____

Primary Address and zip code _____

Home Phone _____

Cell Phone _____

Email _____

Gender ____Female ____Male Date of Birth (mm/dd/yyyy)____/____/____

Emergency Contact: _____ Phone # _____

Current Occupation _____

Previous Occupation _____

Current Marital Status ____Single ____Married ____Divorced ____Re-Married ____Widowed

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: _____

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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: _____

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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: _____

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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? _____

_____

_____

_____

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

_____

_____

_____

Date: _____ Initials: _____

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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: _____

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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: _____

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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: _____