



## CLIENT INFORMATION

Client Name \_\_\_\_\_

Primary Address and Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

Gender  Female  Male Date of Birth (mm/dd/yyyy) \_\_\_/\_\_\_/\_\_\_

Current Occupation \_\_\_\_\_

Previous Occupation \_\_\_\_\_

Current Marital Status  Single  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? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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: \_\_\_\_\_