Life Balance Counseling

Client Information and History

Name:_____ Age _____ Marital Status _____ Date _____

Other family members:

Name:_____ Age ____ Gender _____ Relationship to you _____

Name:_____ Age ____ Gender _____ Relationship to you _____

Name:_____ Age ____ Gender _____ Relationship to you _____

Name:_____ Age ____ Gender _____ Relationship to you _____

Name:_____ Age ____ Gender _____ Relationship to you _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____ Home Phone: _____ Cell Phone:_____

How can we contact you? (check acceptable contacts) Email ____ Home phone ____ Cell phone ____ US mail ____

Occupation:_____ Employer:_____ How long? _____ Retired? _____

If unemployed, describe your current situation: _____

Spouse/Partner Occupation:_____ Employer:_____ How long? _____

Health History

Current health: _____

Have you been treated for any health condition by a physician in the last year? ____ Yes ____ No

If yes, describe: _____

Are you currently under a doctor's care? _____ If yes, name of doctor: _____

Reason for doctor's care: _____

Chronic or recurring conditions: _____

Major illnesses, hospitalizations or surgeries?_____

What medications or supplements are you taking? (List name and dosage)

_____

_____

Please list any other health problems you have, no matter how insignificant they may be: _____

_____

Have you been hospitalized for a physical illness/injury? _____ Describe: _____

_____

Have you been hospitalized for a mental illness? _____ Describe: _____

_____

Have you received counseling or therapy in the past? _____ If yes, please describe and note when, where, duration, and reason for services: _____

_____

Have you experienced: (Place a check mark by conditions that apply to you)

__ Anxiety __Eating Disorder __ Drug Abuse/Addiction
__ Depression __ Post Traumatic Stress Disorder __ Alcoholism
__ Anger issues __ Adoption Issues __ Abandonment
__ Other List: _____

Social History

Do you drink alcoholic beverages? _____ Frequency? _____

Do you use tobacco products? _____ Smoke? _____ # of packs daily: _____

Drug use history: Describe: _____

Do you exercise? _____ Frequency and type of activity: _____

Do you sleep well? _____ If not, why? _____ Average number of hours daily: _____

What are your hobbies and interests? _____

What percentage of time during the day/night (including work and non-work time) do you spend:

Under normal stress load: ____% Under considerable stress load: ____% Resting or relaxing: ____%

Spiritual History

Religious/Spiritual upbringing: _____

Present affiliation: _____ Is this an important part of your life? _____

Family History

Where were you born? _____ How long have you lived in this area? _____

Do you identify with any ethnic, racial or cultural group? _____ Describe: _____

Father: living ___ deceased ____ unknown ____ (check one) Current age if still living:_____ Where residing: _____

Relationship: _____

Mother: living ___ deceased ____ unknown ____ (check one) Current age if still living:_____ Where residing: _____

Relationship:_____

Do you have Step Parent(s)? _____ If so, are they living? _____ Where residing: _____ Describe your relationship with them: _____

If you were raised by someone other than your birth parents, please describe: _____

_____

Check if applicable: ___ I am adopted ___ I know little about my birth parents or family ____ I have been in foster care

Siblings: Circle your place in the family. If a sibling is deceased, put an X through the placement number:

1st child: M F Age ____ 2nd child: M F Age ____ 3rd child: M F Age ____ 4th child: M F Age ____ 5th child: M F Age ____ 6th child: M F Age ____

Is there a history of drug or alcohol abuse in your family? _____ Domestic violence? _____ Abuse? _____

Is there any history of mental illness in your family? _____ If yes, please describe: _____

_____

Present Status and Situation

Have you had what you would consider to be traumatic experience (s) in your life? _____ If yes, briefly describe: _____

_____

Please describe why you have come for counseling/therapy at this time:_____

_____

Describe the nature of your situation: _____

_____

How long have you had these concerns or challenges? _____

Have you ever had the same or a similar condition? ____ Yes ____ No If yes, when and describe:

_____

Have you had any thoughts of suicide? _____ If so, when? _____ Do you have these thoughts currently? _____

Have you received counseling or therapy in the past? _____ If so, when? _____ Please describe the services you received at that time:_____

What would you like to change in your current situation? _____

_____

What would you like to work on in therapy? _____

_____

Please give any other information you think will be helpful for your counselor:

_____

_____

_____

_____

_____

_____