Healthy Lifestyles PLLC
HealthyLifestylesPLLC@gmail.com
469 854 1656

Your Name:

Client Information

Please complete the following information and bring to your first session. If you are unsure about how to answer any of the questions, please leave them to discuss in the session.

Name: ____**Date of Birth:** ______________________

Address: ____

Tel :(H) ________________**Tel :(W)** _________________**Tel: (C)**_____________________

Email Address:___________________________________

May I contact you at: 1. Phone(Y/N)   2. Address (Y/N)   3. Email (Y/N)

Name of professional/resource who referred you:____________________________________

How would you describe your current problem?

____

____

What are your goals for treatment?

____

____

Medical History: La

Other Medical Problems:	**Treatment/Medications/Supplements:**
1.____	**1.**_____________________________
2.____	**2.**_____________________________
3.____	**3.**_____________________________

Food Allergies/Intolerances:

List any food allergies or intolerances you may have:

Please provide names and contact numbers of other physicians, psychiatrists or therapists involved in your healthcare:

1____

2____

Date of Last Physical: **Date of Last Lab Report:**

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Family History:

Relative	Name	Current age or Age at death.	Illnesses or cause of death if deceased	History of Substance Abuse(SA) Or Mental Illness (MI)
Spouse/Partner				
Child				
Child				
Child				
Father				
Mother				
Stepparents				
Grandparents (m)				
(m)				
(p)				
(p)				
Uncles/Aunts				
Brothers/Sisters				

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Family Relationships: (Describe the following relationships)

Your parents' relationship with each other:

(Past)____

(Present)____

Your parents' relationship with you:

(Past)____

(Present)____

Your parent's relationship with your siblings:

(Past)____

(Present)____

Your parents' relationship with other family members:

(Past)____

(Present)____

Your relationship with your siblings in the past and present:

(Past)____

(Present)____

Your siblings' relationships with each other:

(Past)____(

(Present)____

Your relationship with your current spouse/partner:

____

____

Your relationships with ex-spouses/partners: (Describe length and why it ended)

____

____

Your relationship with your children :(List biological, adopted, stepchildren)

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Abuse History:

Please describe any incidences where you were abused :(indicate by whom, when and where and how long)

- **Physically abused**____
  ____
- **Sexually abused**____
  ____

  Neglected____
  ____
- **Emotionally abused**____
  ____

Substance Abuse History:

Cigarettes: Y/N   Packs per day/Frequency: ____________________________________

Alcohol: Y/N Type/Frequency____

Drugs: Y/N Type /Frequency____

Please list any treatment you have received for substance abuse in the past. (Please indicate where and when).

____

____

____

Mental Health History:

Have you ever received medicine or counseling services/ long term treatment for emotional or psychiatric problems before? (If so, please provide details about when and the facility).

____

____

____

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Education and Employment History:

Education/Degree	Institution	Dates Attended	Completion? Y/N

Is there a history of a learning disability?
____

Employment/Job Title	Company	Dates Employed	Reason for Termination

Legal History: **(List any history of involvement with the police or judicial system)**
____
____

Military History: **(Describe any training or service in the military)**
____
____

Religious Affiliations: **(Describe the role your spirituality plays in your life).**
____
____
____

Immigration History: **(If applicable, describe when you immigrated to the United States, where from and under what conditions. How have you/your family adjusted to the change?)**____
____