Healthy Lifestyles

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 blank to discuss in the session.

Name: _____ Date of Birth: _____

Address: _____

Tel:(H)_____ Tel:(W)_____ Tel:(C)_____

Email Address: _____

May I contact you by: 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

Other Medical Problems	Treatments/Medications/Supplements
1._____	1._____
2._____	2._____
3._____	3._____

Food Allergies/Intolerances: List any food allergies you may have:

_____

_____

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

1._____

2._____

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469-854-1656

Name_____

Date of Last Physical_____ Date of Last Lab Report_____

Family History

Relative	Name	Age (Current or at death	Illnesses or cause of death	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				

Family Relationships: (Describe the following relationships)

Your parents' relationship with each other:

(Past)_____

(Present)_____

Your parents' relationship with you:

(Past)_____

(Present)_____

Your parents' relationship with your siblings:

(Past)_____

(Present)_____

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Name_____

Your parents' relationship with other family members:

(Past)_____

(Present)_____

Your relationship with your siblings:

(Past)_____

(Present)_____

Your siblings' relationships with each other:

(Past)_____

(Present)_____

Your relationship with your current spouse/partner:

_____

_____

Your relationships with ex-spouses/partners: (How long was the relationship and why it ended)

_____

_____

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

_____

_____

_____

Abuse History:

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

- Physical abuse_____
  _____
- Sexual abuse_____
  _____
- Neglect_____
  _____
- Emotional abuse_____
  _____

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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, provide details about when and facility.)

_____

_____

_____

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 Leaving

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Name_____

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, where from and under what conditions you immigrated to the United States. How have you/your family adjusted to the change?)

_____

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