

Name: _____

Life

Coaching and Counseling
Center, LLC
18245 Paulson Drive, Suite 116
Port Charlotte, FL 33948

"That all may have life, life in all its fullness." - John 10:10

Client Name: _____ Date: _____

Client Age and Date of Birth: _____ Gender: ☐ Male ☐ Female

Primary Language Spoken: _____

Email Address: _____

Name the presenting problem(s) for which you/your child are seeking help:

1. _____
2. _____
3. _____

What are your/your child's treatment goals?

Presenting Symptom Checklist (check box for any symptoms present) which may cause distress or impairment in Social, Occupational, or other important areas of functioning:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Concentration/Forgetfulness | <input type="checkbox"/> Impulsivity |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Excessive Guilt | <input type="checkbox"/> Increased/Decreased libido | <input type="checkbox"/> Angry Outbursts |
| <input type="checkbox"/> Phobias | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Increased Risky Behavior | <input type="checkbox"/> Crying Spells |
| <input type="checkbox"/> Excessive Worry | <input type="checkbox"/> Excessive Energy | <input type="checkbox"/> Increased Irritability | <input type="checkbox"/> Low Self-Esteem |
| <input type="checkbox"/> Cutting | <input type="checkbox"/> Suspiciousness | <input type="checkbox"/> Poor Social Interactions | <input type="checkbox"/> Suspiciousness |
| <input type="checkbox"/> Delusions
(e.g., Grandiose, etc.) | <input type="checkbox"/> Loss of Interest
(in previously
enjoyed activities) | <input type="checkbox"/> Sleep pattern disturbance
(Hypersomnia/Insomnia) | <input type="checkbox"/> Audio/Visual
Hallucinations |
| <input type="checkbox"/> Hypervigilance | <input type="checkbox"/> Flash Backs | <input type="checkbox"/> Obsessions/Compulsions | <input type="checkbox"/> Avoidance |
| <input type="checkbox"/> Unintentional Weight Gain/Loss | | <input type="checkbox"/> Anxiety/Panic Attacks | |
| <input type="checkbox"/> Verbal/Physical/Aggressive Behavior | | <input type="checkbox"/> Other: _____ | |

Name:

Are there any biological, psychological, and/or social concerns that can be attributed to his/her/your condition?

☐ Yes ☐ No If yes, please explain:

Suicide/Homicide Risk Assessment:

Do you feel or have thoughts that you would like to harm yourself or someone else? ☐ Yes ☐ No

Have you thought about how you would kill yourself or someone else?_____

Is the method you would use readily available?_____

Have you planned a time for this?_____

Is there anything that would stop you from killing yourself or someone else?_____

Have you tried to kill or harm yourself or anyone else before?_____

If yes, please explain._____

Have you ever had feelings or thoughts that you didn't want to live? ☐ Yes ☐ No

If YES, please answer the following. If NO, please skip to the next section.

Do you feel hopeless and/or worthless?_____

Do you currently feel that you don't want to live? ☐ Yes ☐ No

How often do you have these thoughts?_____

When was the last time you had thoughts of dying?_____

Has anything happened recently to make you feel that way?_____

On a scale of 1 to 10 (10 being the strongest), how strong is your desire to kill yourself currently?_____

Would anything make it better?_____

Medical History:

Allergies:_____

Current or over-the-counter medications or supplements:

Name:

Current Medical Problems:

Past medical problems, non-psychiatric hospitalizations, or surgeries:

Date and place of last physical exam:_____

Personal and Family Medical History:

Thyroid Disease	Kidney Disease	Cancer (type)_____
Anemia	Diabetes	Fibromyalgia
Liver Disease	Asthma/Respiratory Problems	Heart Disease
Chronic Fatigue	Stomach/Intestinal Problems	Epilepsy or Seizures
Chronic Pain	High Cholesterol	High Blood Pressure
Head Trauma	Liver Problems	

Other (Specify):_____

Condition:

Which Family Member:

Is there any additional personal or family medical history? ☐Yes ☐No If yes, please explain:

When your mother was pregnant with you, (or you were pregnant with your child), were there any complications related to this pregnancy? (Pre-, during and/or Peri-natal) ☐Yes ☐No If yes, please explain:

Are you (or your child) current with all immunizations? ☐Yes ☐No If no, please explain:

Name:

Past Psychiatric History:

Outpatient treatment ? ☐ Yes ☐ No If yes, please describe below when, by whom, and nature of treatment.

Reason

Dates Treated

By Whom

Psychiatric Hospitalization? ☐ Yes ☐ No If yes, please describe for what reason, when, and where.

Reason

Date Hospitalized

Where

Past psychiatric medications: IF you have ever taken any of the following medications, please indicate the dates, dosages, and how helpful they were (if you can't remember all the details, just write in what you do remember).

Antidepressants:

Prozac (fluoxetine)

Zoloft (sertraline)

Luvox (fluvoxamine)

Paxil (paroxetine)

Celexa (citalopram)

Lexapro (escitalopram)

Effexor (venlafaxine)

Cymbalta (duloxetine)

Wellbutrin (bupropion)

Remeron (mirtazapine)

Serzone (neazodone)

Anafranil (clomipramine)

Pamelor (nortriptyline)

Tofranil (imipramine)

Elavil (amitriptyline)

Mood Stabilizers:

Tegretol (carbamazepine)

Depakote (valproate)

Lithium

Lamictal (lamotrigine)

Topomax (topiramate)

Antipsychotic/Mood Stabilizer Medications:

Seroquel (quetiapine)

Zyprexa (olanzapine)

Geodon (ziprasidone)

Abilify (aripiprazole)

Clozril (clozapine)

Haldol (haloperidol)

Prolixin (thiophenazine)

Risperdal (risperidone)

Sedatives/Hypnotics:

Ambien (zolpidem)

Sonata (zaleplon)

Rozerem (ramelteon)

Restoril (temazepam)

Desyrel (trazadone)

ADHD Medications:

Adderall (amphetamine)

Concerta (methylphenidate)

Ritalin (methylphenidate)

Strattera (atomoxetine)

Anti-Anxiety Medications:

Xanax (alprazolam)

Ativan (lorazepam)

Klonopin (clonazepam)

Valium (diazepam)

Tranxene (clorazepate)

Buspar (buspirone)

Name:

List ALL current medications and how often you take them (If none, write none):

Medication Name	Total Daily Dosage	Estimated Start Date

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for: (Circle)

Bipolar Disorder	Depression	Anxiety	Anger	Suicide	Schizophrenia
Post-traumatic Stress Disorder		Alcohol Abuse		Other substance abuse	Violence

If yes, who had each problem?

Has any family member been treated with a psychiatric medication? ☐ Yes ☐ No

If yes, who was treated, what medications did they take, and how effective was the treatment?

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ☐ Yes ☐ No

If yes, for what substances?_____

If yes, where were you treated and when?

How many days per week do you drink alcohol?_____

What is the least number of drinks you will drink in a day?_____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day?

Have you ever felt you ought to cut down on your drinking or drug use? ☐ Yes ☐ No

Name: _____

Have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No

Have you ever felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ☐ Yes ☐ No

Do you think you may have a problem with alcohol or drug use? ☐ Yes ☐ No

Have you used any street drug within the past three months? ☐ Yes ☐ No

If yes, which ones? _____

Have you ever abused prescription medication? ☐ Yes ☐ No

If yes, which ones? _____

Circle if you have ever tried the following:

Methamphetamine	Cocaine	Stimulants (pills)	Heroin	LSD or Hallucinogens
Pain Killers (not as prescribed)	Methadone	Alcohol	Ecstasy	Tranquilizers/sleeping pills

Other: _____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Tobacco History:

Have you ever smoked cigarettes? ☐ Yes ☐ No

Currently? ☐ Yes ☐ No How many packs per day on average? _____ In the past? ☐ Yes ☐ No

How many years did you smoke? _____ When did you quit? _____

Do you smoke pipes or cigars or use chewing tobacco? ☐ Yes ☐ No In the past? ☐ Yes ☐ No

What kind? _____ How often per day on average? _____ How many years? _____

Family Background and Childhood History:

Were you adopted? ☐ Yes ☐ No Where did you grow up? _____

List your siblings and their ages: _____

What is/was your father's occupation? _____

What is/was your mother's occupation? _____

Did your parents divorce? ☐ Yes ☐ No If so, how old were you when they divorced? _____

Name: _____

If your parents divorced, who did you live with? _____

Describe your father and your relationship with him.

Describe your mother and your relationship with her.

How old were you when you left home? _____

Has anyone in your immediate family died? ☐ Yes ☐ No

Who, When, and how? _____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically, verbally, or by neglect? ☐ Yes ☐ No

Please describe when, where, and by whom, and was this abuse reported/investigated? ☐ Yes ☐ No

Have you witnessed domestic violence? ☐ Yes ☐ No

Education History:

Do you attend school or college? ☐ Yes ☐ No If so, where do you attend and what grade are you in?

What is your highest level or degree attained? _____

Occupational History:

Are you currently: ☐ Working? ☐ Student? ☐ Unemployed? ☐ Disabled? ☐ Retired?

Where do you work? _____

How long in and what is your present position? _____

Have you ever served in the military? ☐ Yes ☐ No If so, what branch and when? _____

Name:

What type of discharge? _____

Relationship History and Current Family:

Are you currently: ☐ Married? ☐ Partnered? ☐ Divorced? ☐ Single? ☐ Widowed?

How long? _____

If in a relationship, what is your spouse or significant other's occupation? _____

Describe your relationship with your spouse or significant other:

Have you had any prior marriages? ☐ Yes ☐ No If so, how many? _____ How long? _____

Do you have any children? ☐ Yes ☐ No If yes, list ages and gender:

Describe your relationship with your children:

List everyone who currently lives with you:

Legal History:

Have you ever been arrested? ☐ Yes ☐ No Do you have any pending criminal charges? ☐ Yes ☐ No

If yes, please describe and provide current status:

Are you currently involved in any lawsuits (custody battle, civil suits, divorce proceedings)? ☐ Yes ☐ No

If yes, please describe and provide current status:

Name:

Discrimination:

Are you experiencing discrimination in any of these areas?

☐Age ☐Gender ☐Race ☐Sexual Orientation ☐Religion

Explain:

Spiritual Life:

Do you belong to a particular religion or spiritual group? ☐Yes ☐No

If yes, what is the current level of your involvement? _____

Do you find your involvement helpful during time of struggle, or does involvement make things more difficult or stressful for you? ☐Helpful ☐More difficult

Is there anything else you would like us to know?

Mini-Mental Status Exam:

Given: ☐Yes ☐No (See attached)

Clinical Diagnostic Impression:

Name:

Treatment Recommendations:

It has been determined by the undersigned therapist, that these services are medically necessary for the well-being of the client.

Client Signature	Date
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Guardian Signature (if applicable)	Date
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Clinician	Date
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