ABUNDANT SOLUTIONS, LLC
WHERE SOLUTIONS ARE JUST THE BEGINNING

Client Information

Date:_____ Patient #_____ Therapist:_____

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____ Cell Phone:_____

Age:_____ Birth Date:_____ Race:_____ Marital: M S W D Current Grade: _____

Occupation:_____ Employer:_____

Employer's Address:_____ Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____Names and Ages of Children:_____

_____

Name of Nearest Relative:_____ Phone:_____

How were you referred to our office?_____

Family Medical Doctor (first and last name): _____

When healthcare professionals work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____ May we contact you by e-mail if necessary? _____

INSURANCE

Subscriber Information

PRIMARY INSURANCE

Insurance Carrier: _____ ID Number: _____ Grp# _____

Subscriber Info:

Name: _____ DOB: _____ SSN: _____ Relationship to client: _____

Phone Number: _____ Subscriber Address: _____

SECONDARY INSURANCE

Insurance Carrier: _____ ID Number: _____ Grp# _____

Subscriber Info:

Name: _____ DOB: _____ SSN: _____ Relationship to client: _____

Phone Number: _____ Subscriber Address: _____

Client Name: _____ Date: _____

HISTORY OF PRESENT PROBLEM:

Reason for this appointment:_____

_____

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

_____

_____

CLIENT CURRENT & PAST HISTORY

Have you ever experienced:

☒ Anxiety	☐Eating Disorder	☐Grief/Loss
☐ Depression	☐ Adjustment/Transition Issues	☐Divorce/Separation
☐ Anger	☐ Adoption Issues	☐Survivor of Crime
☐ Abandonment	☐ Partner/Family Abuse	☐ HIV Positive
☐ Alcoholism	☐ Sexual Trauma	☐ Drug Addiction

Have you had any major illness, hospitalizations or surgeries? Women, please include information about childbirth (include dates): _____

_____

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

If yes, describe: _____

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

_____

_____

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

_____

_____

SOCIAL HISTORY:

Do you drink alcoholic beverages?_____ If so, how much per week?_____
Do you use any tobacco products?_____Do you smoke?____ If so, packs per day: _____
Do you take vitamin supplements?_____ If so, please list:_____
Do you consume caffeine?_____ If so, how much per day:_____
Do you exercise?_____ If yes, what is the frequency and type of exercise?_____
Do you sleep well at night? _____ If no, why not? _____
What are your hobbies?_____
What percentage of time during the day (at home or at your job away from home) do you spend?
Under normal stress load: _____% Under considerable stress: _____% Resting or relaxed: ____%

Client Name: _____ Date: _____

STRENGTHS:

_____

_____

CHALLENGES:

_____

_____

FAMILY HISTORY:

Parents:

Father: ☐living ☐deceased (check one) Current age if still living:_____

Cause of death and age at death if deceased:_____

Mother: ☐living ☐deceased(check one) Current age if still living:_____

Cause of death and age at death if deceased:_____

Check if applicable to you: ___ I am adopted ___ As an adopted child, little is known of my birth parents or family.

Do you have any family members who suffer from the same condition you do? _____ If so, please list: _____

_____

FAMILY HISTORY (if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

☐ Anxiety	☐Eating Disorder	☐Grief/Loss	☐ Death by suicide
☐ Depression	☐ Adjustment/Transition Issues	☐Divorce/Separation	
☐ Anger	☐ Adoption Issues	☐Survivor of Crime	
☐ Abandonment	☐ Partner/Family Abuse	☐ HIV Positive	
☐ Alcoholism	☐ Sexual Trauma	☐ Drug Addiction	

WHAT LED YOU TO SEEK SUPPORT?

Name _____ **Date** _____

1. What would you like to discuss with your therapist? _____

_____

_____

_____

2. What is your major concern? _____

_____

_____

3. Has this happened before? If so, when was the first time you noticed this issue?_____

How did it originally occur?_____

_____

Has it become worse recently? ☐ Yes ☐ No ☐ Same ☐Better ☐Gradually Worse

If yes, when and how? _____

_____

How frequent is the condition? ☐Constant ☐Intermittent

4. What causes the problem to come on/get worse?

_____

_____

_____

5. Is there anything you can do to relieve your major concern? ☐Yes ☐No If yes, describe:

_____

If no, what have you tried to do that has not helped? _____

_____

6. Any history of suicidal thoughts or attempts? If so, when and what were the circumstances?

_____

_____

7. Who or want do you identify as your current support system? _____

_____

Name _____ **Date** _____

8. Are there any other issues you would like to discuss? ☒Yes ☐No If yes, please describe:

_____

_____

_____

9. Are there any cultural limitations, preferences, or needs your therapist should know about? ☐Yes ☐No If yes, please describe: _____

_____

10. Additional Information: _____

_____

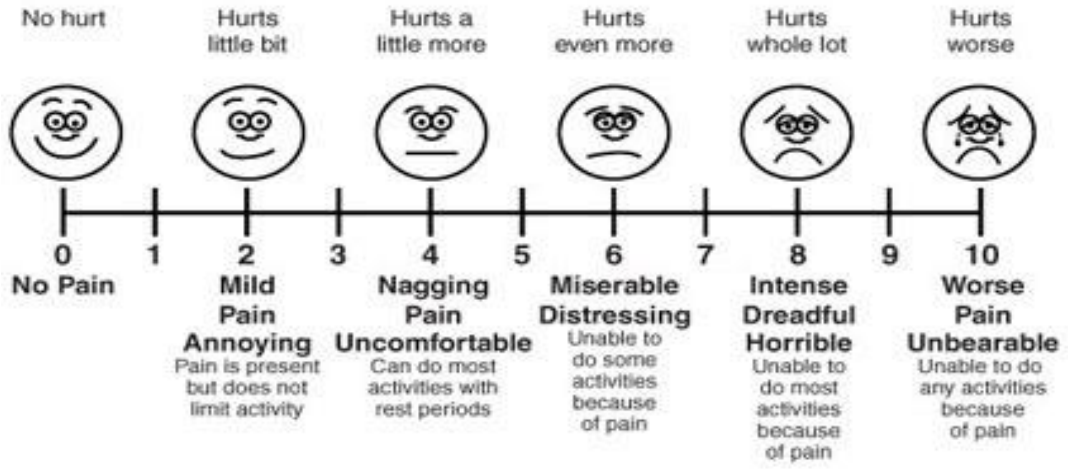
WHERE ARE YOU NOW?

1. Please place an "X" on the line below to indicate level of stress you are currently experiencing.

NO SYMPTOMS/STRESS ——————————————— EXTREME SYMPTOMS/STRESS

2. Please place an "X" on the line below to indicate level of pain you are currently experiencing.

Please consider and include emotional, spiritual, and physical pain.



Therapist's Signature _____ Date _____