Living Life Counseling Demographic Information

Phone (512) 512-966-5405 Fax (512) 864-0930
1504 Leander Road Georgetown, Texas 78628
www.livinglifecounseling.org

Client Name: _____ DOB: _____- Primary Care Doctor: _____ Phone: _____ Specialist Doctor: _____ Phone: _____ Other Treatment Provider chiropractor, nutritionist, acupuncturist:

_____

Illnesses, Conditions, or previous Diagnosis Physical or Mental:

_____

Current Medications and Dosages:

_____

Previous mental health Medications:

_____

What prompted you to call for an appointment?

_____

_____

How were you referred: _____

Have you ever been hospitalized, Physical or Mental:

_____

_____

Any History of abuse? Please Circle Physical Emotional Sexual Emotional Neglect

Have you suffered a traumatic event? Ex. Car Crash, Hurricane, Deployed Military Service, Assault…

_____

Significant Losses in your life and year:

_____

_____

Do you feel like you have resolved these issues? How? _____

Any family history of mental illness? Please circle and indicate what relation: _____

Anxiety Depression Bipolar ADHD Schizophrenia Learning Difficulties

Any family history of substance abuse or addiction? If yes, what relation and substance:

_____

Are there any possible legal issues or court action which is related to you or could be related to your treatment? Yes No If Yes, Please explain:

_____

_____

Signature: _____ Date: _____