LightBalance Counseling
Tina Lightner-Morris, MS, LCPC

Information About You

Date ___________________________

Name ____

Address ____

____

Email Address ____

Home Phone __________________________

Mobile Phone _________________________

Work Phone __________________________

How did you hear about Light Balance Counseling? ____

____

What kind of help do hope to receive? ____

____

With whom are you now living? List people & pets _______________________________________

____

Current Relationship Status
❑Single ❑Engaged ❑Married ❑Separated ❑Divorced ❑Remarried ❑Committed Relationship ❑ Widowed

Significant other's name, age, phone number and occupation ______________________________

____

What brings you to counseling and how long have you been feeling this way? _________________

____

How would you rate the severity of your challenges at this time?
❑Mild ❑Upsetting ❑Moderate ❑Severe ❑Very Severe ❑Extremely Severe ❑Totally incapacitating

Information About You

Health History

List any current and previous therapy:

Type & Why?	With Who?	Dates & Duration	Why Stopped?

Use back if more space is needed.

Any negative experiences with former mental health professionals including psychiatrists?______

____

____

Describe any chronic health problems ____

____

Primary care physician ____

Current Psychiatrist ____

May I contact your physician/psychiatrist if necessary? ❑Yes ❑No ❑Maybe ❑Not Sure

List any current complementary treatments such as acupuncture, massage, etc.________________

____

____

Whom have you previously consulted about your present challenge(s)? _____________________

____

____

Information About You

Please list any prescriptions or over the counter medications you are currently taking.

____

____

____

Please list any supplements, herbal or homeopathic remedies you are currently taking.

____

____

____

Have you ever been hospitalized for a psychiatric problem? ❑Yes ❑No

Have you ever been treated on an outpatient basis for a psychiatric problem? ❑Yes ❑No

If yes to either above question, please give details and your feelings about the experience?

____

____

____

Habits

What is your typical daily diet?

Breakfast	
Snack	
Lunch	
Snack	
Dinner	
Snack	

Information About You

How often do you exercise? ❑Never ❑Rarely ❑Occasionally ❑Often ❑Regularly

What type of exercise do you do?____

____

Do you enjoy your exercise regime? ❑Yes ❑No

Do you use Tobacco? ❑Yes ❑No
If yes, ❑Cigarettes ____packs per day ❑Cigars ____per day ❑Chew/Dip ____ tins per day/week

What is your favorite food type? ____

Do you have any food cravings? ____

____

Do the cravings increase at any particular time or emotion? ________________________________

____

How often do you eat sweets?
❑Multiply times a day ❑Daily ❑Weekly ❑Special Occasions ❑Hormonally ❑Emotionally

How much caffeine you consume daily? ❑Coffee___ ❑Tea___ ❑Sodas___ ❑Chocolate___

How often do you consume alcohol?
❑Multiply times a day ❑Daily ❑Weekly ❑Special Occasions ❑Hormonally ❑Emotionally

What type of alcohol do you drink? ❑Beer ❑Liquor ❑Wine ❑NA

Have you ever had an alcohol related injury? ❑Yes ❑No Please describe ___________________

____

Do you use recreational drugs? ❑Never ❑In the past ❑Recently ❑Regularly

Please describe ____

____

Information About You

Have you or anyone in your family had an addiction to drugs or alcohol? ❑Yes ❑No
Please Explain:

Who?	Substance Abused	
		❑Active Abuse ❑Recovery
		❑Active Abuse ❑Recovery
		❑Active Abuse ❑Recovery

Do you have any issues with sugar regulation such as diabetes or hypoglycemia? ❑Yes ❑No

Does anyone in your family have diabetes or Hypoglycemia? ❑Yes ❑No

Social History

Is there a history of psychiatric issues on either side of your family? ❑Yes ❑No

If so how has that affected you? ____

Is there a history of suicide attempts on either side of your family? ❑Yes ❑No

If so how has that affected you? ____

Any current or past legal issues that are pending or have impacted your current situation?______

____

Where did you grow up? ____

Who raised you? ____

Fathers age_____ , Health _____________________, Occupation _________________________

Stepfather's age_____ , Health ____________________, Occupation ________________________

How did you get alone with your father and/or stepfather as a child? _______________________

____

How do you get along with him now? ____

____

Information About You

Mother's age_____ , Health ____________________, Occupation _________________________

Stepmother's age_____ , Health ___________________, Occupation _______________________

How did you get along with your mother and/or stepmother as a child? _____________________

____

How do you get along with her now? ____

____

Describe your parent's marriage? ____

If your parents have ❑Separated or ❑Divorced how old were you? ________________________

Describe how you were disciplined as a child? ____

____

Who had the greatest influence (both good and bad) on you while growing up? ______________

____

How many times did you move or change schools as a child? ______________________________

What worries or problems did you have as a child? _______________________________________

List first names and ages of siblings in your family including yourself in the lineup.

Name	Age	Half, Step, Adopted	Name	Age	Half, Step, Adopted

How did you get along with your siblings? ____

Education

What is your last grade completed? ____

What Degrees have you earned? ____

Information About You

Did you have any problems with teachers or peers? ❑Yes ❑No If Yes, explain _______________

____

Were you ever ❑suspended or ❑expelled from school? ___________________________________

Did you ever attend boarding school or live away from home to go to school? ❑Yes ❑No

If Yes, explain: ____

Professional History

What is your job? ____

How you feel about your job? ____

My performance at work is ❑Improving ❑The same ❑Declining

Financial History

What is your average annual gross family income? ____

What is your outstanding debt other than mortgage? ____

Describe any financial concerns you may have. ____

____

Adult Life

How do you get along with other people? ____

How do you think others feel about you? ____

How do you let off steam from stress or anger? ____

What are your goals in life? ____

How old were you when you began to date? ____

Age of first sexual experience. __________ Was it ❑positive or ❑negative?

Information About You

If you have children please list their names and ages. ______________________________________

____

List your <u>past</u> significant romantic relationships. Please state if you *<u>dated only,</u>* *<u>lived together, or were married.</u>*
____

____

____

If you have been or are married, please answer the following questions: ❑NA

How long have you been or were you married? ____

How long was your courtship? ____

How old were you when you married?___________ How old was your spouse? _______________

What is your spouse's level of education?____

Are you living with your spouse now? ____

How do you feel about your marriage? ____

How many times have you been married? ____

How many times has your spouse been married? ____

Date of separation and/or divorce? ____

<u>Spirituality</u>

What is your religion and/or spirituality? ____

What role does religion or spirituality play in you life? ______________________________________

What was your religion as a child? ____

What is your significant other's religion or spirituality? _____________________________________

Do you attend or belong to a spiritual community? ____

Information About You

Do you believe there are ways that your spiritual beliefs, background, and lifestyle are impacting your current struggles or strengths? ____

____

____

____

What role, if any do you think spirituality could play in you healing process? _________________

____

____

____

Describe any volunteer work you do or have done? ____________________________________

____

____

What , if any, spiritual practices to you practice on a regular basis?
❑Meditate ❑Prayer ❑Scripture reading or study ❑singing or chanting ❑Dance ❑Retreats ❑Attend services

Please describe your spiritual practice and how often.____________________________________

____

Have you had any significant spiritual experience? ______________________________________

____

How do you feel your relationship with God/Spirit/Higher Power is at this time? ______________

____

What is your greatest source of joy? ____

What is your fondest dream for the future? ____

Information About You

Who are the people who you turn to for support? ______________________________________

____

____

Please list a parent, sibling, or friend who may be contacted in case of emergency, other than significant other.

Name ____ Phone ___________________________

Is there anything else that you feel is important to share ?

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