Abella Counseling, LLC

Client Information

Name _____

Date of Birth _____ Place of Birth _____

Street _____ City _____ State _____ Zip _____

Email _____

Phone (H) _____ (W) _____ (C) _____

Education/Occupation _____ Work Hours _____

Insurance Group Number: _____

Referred by: _____

Emergency Contact Name _____ Phone: _____

Are you currently being treating by a physician or psychiatrist? ☐ Yes ☐ No *If yes list name of the provider(s), date(s), and reason for services.* _____

_____

Do you take any prescription medication? ☐ Yes ☐ No If yes please list: _____

_____

Describe prior assessments and therapy you have received. _____

_____

_____

Describe any serious life stresses you have experienced. Stressors can include physical or sexual abuse, domestic violence, divorce, chronic illness or injury. _____

_____

_____

_____

Household Information

Adults presently living with you:

Name	Relationship	Age	Quality of Relationship

Children presently living with you:

Name	Relationship	Age	Quality of Relationship

Other important people in you life I should know about:

Name	Relationship	Age	Quality of Relationship

Family Health History

Please indicate if you or anyone in your family has ever had any of the following:

	Condition	Relationship/Self	Comments
☐	Serious illness		
☐	Anxiety Disorder		
☐	Obsessive-Compulsive Disorder		
☐	Bipolar Disorder		
☐	Depression		
☐	Learning Disability		
☐	Attention-Deficit Hyperactivity Disorder		
☐	Alcoholism/drug abuse		
☐	Other mental health concerns		
☐	Criminal convictions		

Have you ever felt so sad you wanted to kill yourself? ☐ Yes ☐ No

Did you have a plan? ☐ Yes ☐ No

Did you ever actually hurt yourself? ☐ Yes ☐ No Do you still think about that now? ☐ Yes ☐ No

Does anyone know about this? ☐ Yes ☐ No *If yes who?* _____

Were you hospitalized? ☐ Yes ☐ No

Have you ever felt so angry you were homicidal? ☐ Yes ☐ No

Did you ever actually hurt anyone? ☐ Yes ☐ No Do you still think about that now? ☐ Yes ☐ No

Does anyone know about this? ☐ Yes ☐ No *If yes who?* _____

What do you like about yourself? What are your strengths, interests?

_____

_____

Is there anything you want to change about yourself? _____

_____

_____

What concerns made you seek therapy at this time? _____

_____

_____

_____

What would need to happen for you to feel like therapy was worthwhile?

_____

_____

The content of this form will not be shared with anyone other than when necessary to insure I receive the best possible treatment. Services received are confidential, however there are ethical and legal limits to that confidentiality. I am able to discuss the limits of this confidentiality at any time. I have read and understood the above.

_____ _____

Client Signature Date