MINDFUL LIFE
COUNSELING CENTER PLLC

Mindful Life Counseling Center
15632 Hwy 110 S. Suite 26
Whitehouse TX, 75791 Individual NPI 1629467584/Facility NPI 1134671910/ EIN 81-4155121
903-330-1403

4. Mindful Life Counseling Center Adult Background and History Information

Name:

COMPLETE THIS FORM IF YOU ARE 18 YEARS OF AGE OR OLDER

If under 18 yrs, skip this form and complete Mindful Life Counseling Center Child/Adolescent Background and History Information

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Referred by:

- ☐ Mindful Life Website
- ☐ Psychology Today
- ☐ Medical Provider
- ☐ Friend/Family

Other Referral Source:

Have you previously received any type of mental health services? If yes, which of the following:

(check all that apply)

- ☐ Psychotherapy

- [ ] Medication
- [ ] Outpatient Hospitalization
- [ ] Inpatient Hospitalization

If yes to any of the above, please provide the following information.

Name of provider or facility::

Location::

Dates of treatment::

Reason for treatment::

Education History

Are you currently in school?:

If yes, what school do you attend?:

What is your grade level?:

Have you ever received special education services or and IEP?:

Military History

Are/were you a member of the armed services:

Did you serve in combat?:

If yes, what branch?:

Employment History

Work:

Current Employer::

Job Description:

Length of time at present job::

Are you currently looking

for a job:

Legal History

Have you ever been arrested?:

If yes, what were the charges?:

Do you have any current legal charges pending?:

If yes, please explain:

Medical History

Previous medical conditions:

Previously treated by:

Dates treated:

Previous surgeries:

Previous diagnoses/mental health treatment:

Allergies:

What medications are you currently using?:

Previous medications:

Exercise Frequency:

Exercise Type:

Family History

Were you adopted? If yes, at what age?:

How is your relationship with your mother?:

How is your relationship with your father?:

Siblings and their ages:

Who raised you? Where did you grown up?:

Family member medical conditions:

Family member mental conditions:

Present Situation

Never Married:

Domestic Partner:

Married:

Seperated:

Divorced:

Widowed:

How is your relationship with your partner?:

Do you have child(ren)? If yes, how is your relationship with your child(ren)?:

Do you consider yourself to be spiritual or religious? If yes, describe your faith or belief: :

What do you consider to be some of your strengths and weaknesses?:

What do you enjoy doing in your free time? What do you do to relax? :

Who do you have in your life for support?:

Mental Health

What brings you in today?:

How are these problems currently interfering in your life?:

When did your problem first start?:

Please describe any major losses or traumas you have experienced. :

Have you ever attempted to commit suicide in the past?:

If yes, please describe when this occurred and what was happening in your life at that time. :

Do you engage in any other risk-taking or self-harming behaviors?:

If yes, please explain.:

Current Symptoms

(check all that apply)

- ☐ Appetite Issues
- ☐ Avoiding People or Situations
- ☐ Being Disorganized or LosingThings
- ☐ Crying Spells
- ☐ Excessive Energy
- ☐ Difficulty Making Decisions
- ☐ Fatigue
- ☐ Feeling Anxious or Worried
- ☐ Feeling Sad/Down
- ☐ Guilt
- ☐ Hallucinations
- ☐ Impulsivity
- ☐ Irritability

- [ ] Increased Substance Use
- [ ] Libido Changes
- [ ] Losing Track of Time
- [ ] Loss of Interest
- [ ] Obsessive Thoughts About an Event
- [ ] Panic Attacks
- [ ] Racing Thoughts
- [ ] Relationship Difficulities
- [ ] Risky Activity
- [ ] Sleep Changes
- [ ] Suspiciousness
- [ ] Unpleasant Thoughts About an Event

Other Concern:

Do you currently use or have you ever had problems due to the use of the following?

(check all that apply)

- [ ] Alcohol
- [ ] Tobacco
- [ ] Marijuanna
- [ ] Abuse of Prescription Medication
- [ ] Pain Medication

If prescription medication, please list:

- [ ] Other Substances

If other, please list.:

If yes to any, list frequency/dates of use:

Have you ever been treated for drug/alcohol abuse? If yes, when?:

Do you smoke cigarettes? If yes, how many per day?:

Additional

Is there any other information that you would like to share?:

(if completing paperwork electronically, signature will be required after completion of all forms)

Signature:

Date: