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

5. Mindful Life Counseling Center Child/Adolescent Background and History Information

Name:

COMPLETE THIS FORM IF YOU OR YOUR CHILD IS 17 YEARS OF AGE OR YOUNGER

If over 18 yrs, skip this form and complete Mindful Life Counseling Center Adult 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.

Person completing this form (please note that this form has been adapted to allow either parent or minor client to complete this form, please proceed with the method most comfortable for your family). If you have any questions or comments, please do not hesitate to ask.

I am the client:

Your name if not the client::

Relationship to the client::

Referred by:

☐ Mindful Life Website

- [ ] Psychology Today
- [ ] Medical Provider
- [ ] Friend/Family

Other Referral Sources:

Have you/your child 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/your child currently in school?:

If yes, what school do you attend?:

What is your grade level?:

Grades/Current Performance

- [ ] Well below average
- [ ] Below average
- [ ] Average
- [ ] Above average
- [ ] Well above average

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

Employment History

Work:

Current Employer::

Job Description:

Length of time at present job::

Are you/is your child currently looking for a job:

Legal History

Have you/your child ever been arrested?:

If yes, what were the charges?:

Do you/your child 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/your child currently using?:

Previous medications:

Exercise Frequency:

Exercise Type:

Family History

Were you/your child adopted? If yes, at what age?:

How is your/your child's relationship with their mother?:

How is your/your child's relationship with their father?:

Siblings and their ages:

Who is raising you/your child? Where did you grown up?:

Family member medical conditions:

Family member mental conditions:

Present Situation

Parental Marital Status

Never Married:

Domestic Partner:

Married:

Seperated:

Divorced:

Widowed:

If separated/divorced how old was child when separation occurred?:

Do is their a custody

agreement/court order?:

If yes, please describe. :

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

What do you consider to be some of your/your child's strengths and weaknesses?:

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

Who do you/does your child have in your life for support?:

Mental Health

What brings you in today?:

How are these problems currently interfering in your/your child's life?:

When did the problem first start?:

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

Have you/your child ever attempted suicide in the past?:

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

Do you/your child 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 Losing Things
- [ ] 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 Symptom:

Current Issues

(check all that apply)

- [ ] Being Bullied

- [ ] Bullying Others
- [ ] Cheating at School
- [ ] Dating Problems
- [ ] Destruction of Property
- [ ] Divorce
- [ ] Drug Alcohol Use
- [ ] Family Conflict
- [ ] Gang Involvement
- [ ] Loss/Death
- [ ] Lying
- [ ] Peer Issues
- [ ] Risk Taking Behavior
- [ ] Running Away From Home
- [ ] School Attendance
- [ ] Sexual Related Concerns
- [ ] Sibling Issues

Other Issues:

Have you/your child Do you currently use or have you ever had problems due to the use of the following?

(check all that apply)

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

If prescription medication, please list:

- [ ] Other Substances

If other, please list:

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

Have you/your child ever been treated for drug/alcohol abuse? If yes,

when?:

Do you/does your child 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:

Parent/Guardian Signature if client under the age of 18:

Date: