Holistic Mental Health Services

Client Information

Client: _____ DOB: _____ Gender: _____ Pronouns:_____

Client: _____ DOB: _____ Gender: _____ Pronouns:_____

Client Address: _____

Client Phone(s): _____ Client email address: _____

For Astrological services: City, State of birth _____ Exact time of birth:_____AM/PM

Parent (1) (if client is minor): _____ Phone: _____

Parent Address: _____

Parent email address: _____

Parent (2): _____ Phone: _____

Parent Address: _____

Parent email address: _____

Reason for seeking services: _____

Current Symptoms: _____

_____

Hobbies, recreation, leisure time activities: _____

_____

_____

What are your strengths:

_____

_____

What are areas you'd like to work on?

_____

_____

Substance use/abuse, eating disorder history:

Substance	Current	Age began	How long used	Amount/Frequency	Problems (legal, work, school)
Alcohol	Yes/No				
Cannabis	Yes/No				
Crack	Yes/No				
Cocaine	Yes/No				
K2	Yes/No				
Meth	Yes/No				
Heroin	Yes/No				
Ketamine	Yes/No				
Psilocybin	Yes/No				
Prescription Medications:	Yes/No				
Bulimia	Yes/No				
Anorexia	Yes/No				
Overeating	Yes/No				
	Yes/No				
	Yes/No				
	Yes/No				
Tobacco	Yes/No				
Other					

Stressful Life Events Inventory

Do you experience any of the following?	Not at all	A little bit	Moderately	Quite a bit	Extremely
Repeated, disturbing, and unwanted memories of a past stressful experience?					
Repeated, disturbing dreams of a past stressful experience?					
Suddenly feeling or acting as if a past stressful experience were actually happening again *(as if you were actually back there reliving it)*?					

Feeling very upset when something reminded you of a past stressful experience?					
Do you experience having physical reactions (heart pounding, trouble breathing or sweating) when something reminded you of a stressful experience from the past?					
Do you frequently avoid thinking about a stressful experience from the past or avoid having feelings related to it?					
Do you frequently avoid activities or situations because they remind you of a stressful experience from the past?					
Do you struggle to remember important parts of a stressful experience from the past?					
Have you had a loss of interest in things you used to enjoy?					
Do you often feel distant or cut off from other people?					
Do you experience feeling emotionally numb or being unable to have loving feelings towards people close to you?					
Do you experience feeling that your future has been or will be cut short?					
Do you experience being super alert or constantly on guard?					
Do you experience feeling jumpy or easily startled?					

Mental Health History

Any previous mental health treatment services in the past? Yes/no If yes, please list dates and duration below:

_____

_____

What were treatment goals:_____

What were previous diagnoses:_____

What therapy models have you utilized in the past?_____

Do you have a history of self-harm or suicide ideation? Yes/no

Have you been hospitalized for mental health reasons? Yes/no If yes, please list dates/hospital below:

_____

_____

Do you have a history of hallucinations or delusions? Yes/no If yes, please describe below:

_____

_____

Do you currently take prescription medication or supplements: yes/no If yes, please list below:

Medication/Supplement name	**Dosage amount**	**Reason taking**	**Frequency**	**How long have you been taking?**	**Do you consider it effective?**

Physical Health History

Developmental history

Where were you born?_____

Were there complications with your mother's pregnancy or your birth? If yes, please explain _____

_____

Are you aware of any delays or difficulties during your early childhood (toilet training, speaking, crawling, walking, etc)?

_____

_____

Did you experience any ongoing childhood chronic medical problems or serious injuries? _____

_____

Current history

Do you have any chronic/ongoing illness/diagnoses? Yes/no If yes, please list below:

_____

_____

Do you exercise regularly? Yes/no If yes, please list activity and frequency below:

_____

_____

Do you have any food or environmental allergies? Yes/No If yes, please provide details below:

_____

_____

How many ounces of water do you drink on a daily basis? _____

Do any of the diets/eating preferences apply? Vegan/Vegetarian/Pescatarian/Keto/Paleo/Mediterranean

Other: _____

Is there a daily consumption of caffeine? Yes/No If yes, please describe _____

_____

What is your average amount of sleep time per day? _____

Do you have good energy throughout the whole day? Yes/No If no, please explain: _____

_____

Do you feel refreshed when awakening? Yes/No Do you work an overnight "grave yard" shift? Yes/No

Do you go to sleep with/utilize throughout the night a TV or other noise producing machines to fall/stay asleep? Yes/No

Please describe? _____

What are the activities you perform 1-2 hours prior to bedtime? _____

_____

Do you have frequent headaches? Yes/No If yes, how many per week? _____

How do you relieve the pain? _____

Do you have any history of a traumatic brain injury (TBI)? Yes/No If yes, please describe_____

_____

Education:

Highest educational level completed: _____ Are you currently a student? Yes/No

If yes, how many hours are you currently taking? _____ What's your field of study? _____

Clients under 18:

Scholastic abilities (strengths/weaknesses): _____

Problems with: truancy/suspensions/special education/vocational training Yes/No

Relationships with teachers/peers? Yes/No If Yes explain: _____

Emotional Intelligence

Do you feel you are emotionally intelligent? _____

Do you feel that you become irritated or angered quickly? _____

Are you able to self-sooth and calm yourself when becoming upset or angry?_____

Are you aware of your feelings and why you feel that way? _____

Do you recognize when your behaviors impact others? _____

Employment:

Current Employment status: _____ How long have you been there? _____

Current job title: _____ What are your daily duties? _____

_____

How satisfied with current employment: Very Somewhat Not at all

Previous jobs/reasons for leaving: _____

Spirituality:

Do you consider yourself spiritual or religious? _____

Are you part of a spiritual or religious community? Yes/No If Yes explain: _____

_____

What importance does your faith or belief have in your life?_____

_____

Relationship status: (check all that apply)

Single__ Divorced__ Separated__ Co-habitating__ LGBTQIA ___ Married____ Poly____ Consensual Non-Monogamy___

Children: Yes/No

Name	Age	Medical Problems	Behavioral Problems	Learning Problems	Where does child live?

Is the other parent involved in care of child? Yes/No Please describe: _____

_____

Is there a regular and consistent visitation schedule in place? Yes/No/NA

Stepchildren: Yes/No

Name	Age	Medical Problems	Behavioral Problems	Learning Problems	Where does child live?

Problems/difficulties with parent/stepparent relationship? Yes/No If yes explain _____

Family History

Is your mother living? _____Mother's age?_____ Where does your mother live?_____

Mother's occupation?_____ Mother's values when growing up?_____

Describe your current relationship with your mother _____

What was your relationship with you mother like while were growing up?_____

_____

Is your father living? _____father's age?_____ Where does your father live?_____

Father's occupation?_____ Father's values when growing up?_____

Describe your current relationship with your father._____

What was your relationship with you father like while growing up?_____

_____

Describe your parents' relationship with each other while you were growing up _____

_____

What is your current relationship with your parents like now? _____

_____

Were you adopted? _____ If yes, what do you know about your birth parents? _____

_____

Do you have siblings? How were those relationships? _____

_____

Where are you in the birth order? ____Oldest _____Youngest _____Middle

Describe any major cultural influences within your family as a child growing up _____

_____

Describe your family growing up _____

_____

Did you experience physical, sexual, mental, emotional abuse or neglect when growing up? If yes, please describe.

_____

_____

Do you know of any other traumatic events while growing up? If yes, please describe. _____

_____

_____

Do any family members have a history of mental illness or addiction? If yes, please describe. _____

_____

_____

_____

How do you think growing up in your family impacted you as an adult? _____

_____

_____

Any additional or relevant information you'd like to share?

_____

_____

_____

_____

_____

_____

_____

In the event of an emergency during our session, who should I contact and notify of the emergency?

_____	_____	_____
Name	**Relationship**	**Phone Number**

_____ _____

Client/Parent **Date**

_____ _____

Client/Parent **Date**