Alex Saunders, LCPC, LAC
Conscious Counseling Services, PLLC
406.570.2241
1201 Highway 10 W. Unit A4D
Livingston, MT 59047
yourconsciousself.com

Client History and Basic Information

Date: _____

***This practitioner is a mandatory reporter and as such, please be aware that *thoughts of harming others or self is not reportable, though may result in further exploration and an enactment of a safety plan*. This is a safe space to talk about suicidal thoughts. The ACTUAL past or present ACTION or future INTENTION or PLAN to harm someone who is underaged, elderly, disabled, or considered unable to protect themselves will be reported to appropriate authorities to ensure safety of all. Please feel free to ask any clarifying questions before proceeding. This office is not properly trained in sexual offense and will refer to appropriate services, if needed. Please acknowledge your understanding below:**

Signature: _____ Printed Name:_____

Referral Source

Who referred you to this office or how did you learn about this practice? _____

Assigned Therapist: _____

Reason for coming in today:

_____

_____

_____

Client Name: _____ Nickname:_____

Date of Birth: _____

Gender Identity : _____ Gender assigned at birth: _____

Sexual Orientation : _____

Relationship Status: _____ Gender of partner: _____

Sexual orientation of partner:_____

Ethnicity: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ May we leave a message? [ ] Yes [ ] No

Cell Phone Number: _____ May we leave a message? [ ] Yes [ ] No

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Medications currently prescribed and taking:

Med:_____ Reason:_____ Dosage/Frequency:_____ Prescribing Dr.:_____
Med:_____ Reason:_____ Dosage/Frequency:_____ Prescribing Dr.:_____
Med:_____ Reason:_____ Dosage/Frequency:_____ Prescribing Dr.:_____
Med:_____ Reason:_____ Dosage/Frequency:_____ Prescribing Dr.:_____

Emergency Contact Information:

In case of an emergency, who should we contact? _____

Name: _____

Relationship: _____

Address: _____

City: _____ State:_____ Zip Code: _____

Phone Number: _____ Alternative phone number: _____

If you will be using insurance to cover your sessions or a portion of the cost please complete the following and allow us to make a photocopy of your insurance card:

Self Pay: Y / N Would you like to discuss a sliding fee option: Y / N / Unsure

Primary Insurance Company:_____

Insured name on card:_____

(If insured is other than self): Relationship to insured: _____ Insured Date of birth: _____

*Insured address:*_____

Member ID #:_____

Group #:_____

Copay: _____

Do you have to meet a deductible before your insurance pays for services? : Y / N / Unsure

Secondary Insurance Company if applicable:

_____

_____

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Current Physical Health Status

Height:_____ Weight:_____
Satisfaction or issues with weight: _____

Current Medical Issues/Concerns/Diagnosis:	Intensity (Avg 0-10):	Treatment:	Other:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Energy Healing: _____

Manual Therapy:_____

Other treatments:_____

Past medical issues: _____

Surgery history:_____

Mental Health History

Current Issues/Concerns/Diagnosis:	Intensity (Avg 0-10):	Treatment:	Other:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

History of psychotherapy: _____

Reservations about psychotherapy:_____

Nutrition

Describe your diet: Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

Other (snacks, fasts, cleanses, etc.):_____

Special Diet (vegan, paleo, keto, etc)_____

Known food allergies/sensitivities:

_____

Issues Related to food (binging, purging, etc.) _____

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Sleep

How many hours of sleep per night (average): _____How long to fall asleep? _____Discomfort? _____

How often do you wake at night?_____How long to fall asleep after night waking?_____Do you feel rested?_____

Issues with sleep (nightmares, frequent urination, etc)?: _____

Substance Use (including alcohol)

Recreational substance use: _____ ____Frequency:_____

_____ ____Frequency:_____

_____ ____Frequency:_____

History of addiction: _____

_____

Family history of addiction: _____

Religion/Spirituality

What belief system were you raised in?:_____

Describe current belief system: _____

Rituals associated with beliefs: _____

Issues with belief system/personal expectations?:_____

Family of Origin (FOO) and Current Family

Describe relationship with FOO: _____

_____

_____

Satisfied with Current relationship with FOO:_____

What (if anything) would you change:_____

Current family in home:_____

Describe relationship:_____

_____

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Relationship History

Length of current relationship: _____ Length of longest relationship: _____

Relationship regret?: _____

_____

Describe current relationship: _____

_____

Body Image

Satisfaction or issues with current body: _____

Thought Patterns

Describe thought patterns:_____

Have you experienced disturbing thoughts?: _____ Describe:_____

Suicidal Thoughts: Past:_____ Current:_____

Do you meditate?:_____

Recreation

Describe recreational hobbies: _____

Satisfaction or issues with recreational life:_____

Work

Current work:_____ Satisfaction level: _____

Goals

How long do you believe you will be in therapy: _____

Personal goals you would like to achieve with this practitioner:

_____

_____

_____

Possible issues preventing therapeutic progress: _____

_____