Welcome to Redeeming Love LLC

To better assist you, we ask that you please answer the following questions along with the other questionnaires in this packet. If you need assistance, please call 636-221-8178. We may be in session when you call, so please leave a message and we'll call you back.

Client Name: _____ Date of Birth: _____

Have you received a DUI/DWI in the past 6 months? ☐ Yes ☐ No

- If **Yes** to the question above, please do not continue filling out this form. No services will be provided to you. You will be referred out.
- If **No** to the question above, please continue filling out the form.

If you are seeking substance abuse treatment, trauma therapy (ie. DBT, EMDR), sex therapy, separation/mediation therapy, gambling or other process addiction therapy, personality disorder related therapy, LGBTQ specialized therapy, eating disorder treatment or domestic violence related therapy please stop filling out the forms. Redeeming Love LLC does not specialize in these areas and will make appropriate referrals if needed.

DEMOGRAPHIC INFORMATION

Client address: _____ City:_____ State: _____
Zip code: _____ Client Phone: _____ Text?: ☐ Yes ☐ No
Client Email: _____
Client Social Security Number: _____

Sex (Assigned at Birth): ☐ Female ☐ Male		
Gender Identity: ☐ Female ☐ Male ☐ Non-Binary ☐ Not Specified ☐ Unknown		
Sexual Orientation: ☐ Choose not to disclose ☐ Bisexual ☐ Lesbian, gay, homosexual ☐ Pansexual ☐ Straight, heterosexual ☐ Other ☐ Unknown		
Preferred Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other:		
Race: ☐ African-American ☐ American Indian or Alaskan ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander ☐ White or Caucasian ☐ Unknown ☐ Other:		
Ethnic Origin: ☐ Hispanic Origin: Cuban ☐ Hispanic Origin: Mexican ☐ Hispanic Origin: Other ☐ Hispanic Origin: Puerto Rican ☐ Not of Hispanic Origin		
Highest Level of Education:		
Marital Status: ☐ Living as Married ☐ Never Married ☐ Widowed ☐ Common Law ☐ Living Together ☐ Remarried ☐ Unknown ☐ Divorced ☐ Married ☐ Separated		
Hearing Status: ☐ Normal ☐ Deaf ☐ Hard of Hearing ☐ Unknown		
Primary Language:	**Preferred Language:**	
Employment Status:	☐ Employed Full Time	☐ Employed Part Time
Occupation:		

Veteran: ☐ Yes ☐ No Branch: From/To Dates:

Living Arrangements:

_____
_____
_____
_____

Annual Household Income: $_____

Number in the Household: _____

EMERGENCY INFORMATION

Emergency Contact Name and Phone Number: _____
Emergency Contact Relationship to Client: _____

GUARDIAN INFORMATION

Name of Guardian (if you are not your own Guardian): _____
Guardian Contact Information:
Phone: _____ Address: _____

PRESENTING CONCERNS:

☐ Anger ☐ Anxiety ☐ Behavioral Issues ☐ Bi-polar Disorder ☐ Depression ☐ Family Issues

☐ Relationship Issues ☐ Employment Issues ☐ Financial Issues ☐ Parenting Issues

☐ Stress ☐ Grief or Loss ☐ Marital Issues ☐ Premarital ☐ Physical/Sexual Abuse

☐ Other: _____

Are you satisfied with your eating patterns? ☐ Yes ☐ No
Do you ever eat in secret? ☐ Yes ☐ No

MINI HEALTH SCREEN

Do you have a Primary Care Physician/Pediatrician? ☐ Yes ☐ No
Physician Name: _____
Have you had a physical exam in the last year? ☐ Yes ☐ No
Do you have a dentist? ☐ Yes ☐ No
Have you seen a dentist in the past year? ☐ Yes ☐ No
Do you grind your teeth at night? ☐ Yes ☐ No

Have you or close family members (parents/grandparents) been diagnosed with any of the following conditions? (please circle)

	Self		Parent/Grandparent	
Diabetes/Pre-Diabetes	Yes	No	Yes	No
Hyperlipidemia (High Cholesterol)	Yes	No	Yes	No
Obesity	Yes	No	Yes	No
Hypertension (High Blood Pressure)	Yes	No	Yes	No
Cardiovascular (heart) disease	Yes	No	Yes	No

Do you use tobacco or nicotine products (Vape, Juul, cigarettes, cigars, chewing tobacco, etc.)?
☐ Never Used ☐ Daily use ☐ Occasional use ☐ Previous use, none in past 90 days ☐ Unknown

Have you received mental health or substance use treatment in the past? ☐ Yes ☐ No
If yes, please explain: _____
_____

Are you currently receiving behavioral health services from another agency? _____
If so, which agency, and for what purpose? _____

Have you been hospitalized or gone to the emergency department in the last year? _____
Psychiatric Reasons? _____
Medical Reasons?

Are you currently pregnant? Yes No Unknown
If yes, are you receiving prenatal care? Yes No
If yes, name of provider or clinic:

How many times in the past year have you had
Men – 5 or more drinks per day
Women or all adults older than 65 years – 4 or more drinks per day

0-1 times
2-3 times
4-5 times
6+ times

Please list all Prescription Medications you are taking: _____
_____
_____
_____
_____

Please list all Over the Counter Medications you are taking: _____
_____
_____
_____
_____