



YOUR LIVING WELL
YOURLIVINGWELL.NET

KIMBERLY KLINE LPC-SUPERVISOR

1721 West Plano Parkway, Suite 216,

Plano, TX 75075

214-543-5977

kklines5@yahoo.com

Client's Full Legal Name: _____ Date: _____ Preferred Name:

Pronouns: _____ DOB: _____ Gender

Identity: _____

Marital Status: _____ Partner/Spouse Name: _____

EMERGENCY CONTACT NAME AND PHONE NUMBER: _____

Address: _____

Primary language: _____ Occupation: _____ Employer: _____

Do you have friends you talk to?: _____

Hobbies?: _____

Graduated High School? _____ College degree? _____

Any Learning disabilities? _____

Legal History: Do you have a significant history of legal charges? If yes, describe:

Are you currently on probation/parole? Yes / No Have you ever been on probation/parole? Yes No

Have you ever been court-ordered into chemical health or mental health treatment group ? Yes No

Primary Care Physician: _____

Name and City of Clinic: (We will only contact your physician with your direct consent by Release of Information. _____

Name of Psychiatrist/ or Psych Nurse _____

Name and City of clinic: _____

Any inpatient Care? Where? _____ When? _____

ADD MORE IF NEEDED:

Any Allergies requiring special care? _____

Medical Diagnosis?: _____ Year?: _____

Medical Diagnosis?: _____ Year?: _____

Do you have any seizure disorder? Yes / No

List your medications:	Mg /Dose	Purpose	Physician
------------------------	----------	---------	-----------

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.

What is your reason for seeking care?: **Please give some detail**

Depression:

Anxiety:

Sleep Problem:

Relationship Issues:

Parenting Issue:

Work or school Performance:

Sexual Concern:

Legal Issue:

Gender or body dysmorphic issue:

Grief:

Eating disorder:

Substance Abuse:

Divorce related Issue:

Stress Management:

Other:

When did this problem(s) begin?

What changes to you want to happen as a result of counseling?

What strengths do you possess?