

Information About YOU
LightBalance Integrative Health
Dr.Tina Lightner-Morris, LCPC,BCC,IAYT-C

Date _____

Name

Address

Email Address

Home Phone _____

Mobile Phone _____

Work Phone _____

How did you hear about LightBalance? _____

What kind of help do hope to receive?

With whom are you now living? List people & pets

Current Relationship Status

Single Engaged Married Separated Divorced Remarried Committed Relationship
Widowed

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Significant other's name, age, phone number and occupation

What brings you to counseling and how long have you been feeling this way?

How would you rate the severity of your challenges at this time?

Mild Upsetting Moderate Severe Very Severe Extremely Severe Totally
incapacitating

Health History

List any current and previous therapy:

Type & Why?	With Who?	Dates & Duration	Why Stopped?

Use back if more space is needed.

Any negative experiences with former mental health professionals including psychiatrists?_____

Describe any chronic health problems

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Primary care physician

Current Psychiatrist

May I contact your physician/psychiatrist if necessary? Yes No Maybe Not Sure

List any current complementary treatments such as acupuncture, massage, etc. _____

Whom have you previously consulted about your present challenge(s)?

____ Please list any prescriptions or over the counter medications you are currently taking.

____ Please list any supplements, herbal or homeopathic remedies you are currently taking.

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Have you ever been hospitalized for a psychiatric problem? Yes No

Have you ever been treated on an outpatient basis for a psychiatric problem? Yes No

If yes to either above question, please give details and your feelings about the experience?

Habits

What is your typical daily diet?

Breakfast	
Snack	
Lunch	
Snack	
Dinner	
Snack	

How often do you exercise? Never Rarely Occasionally Often Regularly

What type of exercise do you do?

Do you enjoy your exercise regime? Yes No

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Do you use Tobacco? Yes No

If yes, Cigarettes ____ packs per day Cigars ____ per day Chew/Dip ____ tins per day/week

What is your favorite food type?

Do you have any food cravings?

Do the cravings increase at any particular time or emotion?

How often do you eat sweets?

Multiply times a day Daily Weekly Special Occasions Hormonally

Emotionally How much caffeine you consume daily? Coffee____ Tea____

Sodas____ Chocolate____

How often do you consume alcohol?

Multiply times a day Daily Weekly Special Occasions Hormonally Emotionally

What type of alcohol do you drink? Beer Liquor Wine NA

Have you ever had an alcohol related injury? Yes No Please describe

Do you use recreational drugs? Never In the past Recently Regularly

Please describe

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____ Have you or anyone in your family had an addiction to drugs or alcohol? Yes
No Please Explain:

Who?	Substance Abused	
		<input type="checkbox"/> Active Abuse <input type="checkbox"/> Recovery
		<input type="checkbox"/> Active Abuse <input type="checkbox"/> Recovery
		<input type="checkbox"/> Active Abuse <input type="checkbox"/> Recovery

Do you have any issues with sugar regulation such as diabetes or hypoglycemia? Yes
No

Does anyone in your family have diabetes or Hypoglycemia? Yes No

Social History

Is there a history of psychiatric issues on either side of your family? Yes No

If so how has that affected you?

Is there a history of suicide attempts on either side of your family? Yes No

If so how has that affected you?

Any current or past legal issues that are pending or have impacted your current situation?_____

Where did you grow up?

Who raised you?

Fathers age_____, Health _____, Occupation

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Stepfather's age____ , Health _____, Occupation

How did you get along with your father and/or stepfather as a child?

How do you get along with him now?

____ Mother's age____ , Health _____, Occupation

Stepmother's age____ , Health _____, Occupation

How did you get along with your mother and/or stepmother as a child?

How do you get along with her now?

Describe your parent's marriage?

_____ If your parents have

Separated or Divorced how old were you? _____

Describe how you were disciplined as a child?

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Who had the greatest influence (both good and bad) on you while growing up?

How many times did you move or change schools as a child?

_____ What worries or problems did you have as a child?

_____ List first names and ages of siblings in your family including yourself in the lineup.

Name	Age	Half, Step, Adopted	Name	Age	Half, Step, Adopted

How did you get along with your siblings?

Education

What is your last grade completed?

What Degrees have you earned?

_____ Did you have any problems with teachers or peers? Yes No If Yes, explain _____

Were you ever suspended or expelled from school?

Did you ever attend boarding school or live away from home to go to school? Yes No

If Yes, explain:

Professional History

What is your job?

How you feel about your job?

My performance at work is Improving The same Declining

Financial History

What is your average annual gross family income?

What is your outstanding debt other than mortgage?

Describe any financial concerns you may have.

Adult Life

How do you get along with other people?

How do you think others feel about you?

_____ How do you let off steam from

stress or anger? _____

What are your goals in life?

How old were you when you began to date?

Age of first sexual experience. _____ Was it positive or negative?

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If you have children please list their names and ages.

List your past significant romantic relationships. Please state if you *dated only, lived together, or were married.*

If you have been or are married, please answer the following questions: NA

How long have you been or were you married?

How long was your courtship?

How old were you when you married?_____ How old was your spouse?

What is your spouse's level of education?

Are you living with your spouse now?

How do you feel about your marriage?

How many times have you been married?

How many times has your spouse been married?

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Date of separation and/or divorce?

_____ **Spirituality**

What is your religion and/or spirituality?

What role does religion or spirituality play in you life?

What was your religion as a child?

What is your significant other's religion or spirituality?

Do you attend or belong to a spiritual community?

_____ Do you believe there are ways that your spiritual beliefs, background, and lifestyle are impacting your current struggles or strengths? _____

What role, if any do you think spirituality could play in you healing process?

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Describe any volunteer work you do or have done?

What , if any, spiritual practices to you practice on a regular basis?

Meditate Prayer Scripture reading or study singing or chanting Dance Retreats Attend services

Please describe your spiritual practice and how often. _____

Have you had any significant spiritual experience?

How do you feel your relationship with God/Spirit/Higher Power is at this time?

What is your greatest source of joy?

What is your fondest dream for the future?

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