AUTHENTIC CHANGE COUNSELING LLC
JESSICA KIESLER MA, LPC, CRAADC
LICENSED PROFESSIONAL COUNSELOR
T 314-518-5112 F 314-963-7703

Client Name: ______________________________

Social Security # ______________________________

Date of birth: ____________________

Address: ____

Best phone # ____________________ **Is is ok to leave a message here? Y or N**

Other Phone # ____________________ **Is is ok to leave a message here? Y or N**

* If any questions do not apply please leave them blank*

Please circle the response which best describes the level of concern in each area:

Family or partner relationships	None	Minimal	Mild	Moderate	Severe	Extreme
Work or work relationships	None	Minimal	Mild	Moderate	Severe	Extreme
Emotional Concerns: depression, anxiety, stress, etc.	None	Minimal	Mild	Moderate	Severe	Extreme
Physical Health and Wellness	None	Minimal	Mild	Moderate	Severe	Extreme
Past abuse or trauma	None	Minimal	Mild	Moderate	Severe	Extreme
Alcohol or drug use for self	None	Minimal	Mild	Moderate	Severe	Extreme
Concern for other's alcohol or drug use	None	Minimal	Mild	Moderate	Severe	Extreme
Other concerns:	None	Minimal	Mild	Moderate	Severe	Extreme

Have you had any major health issues that signficantly affected your life?	Past	Current	Comments:
Heart, high blood pressure			
Stomach, digestive problems			
Headaches/migraines			
Pain - muscle, arthritis other			
Asthma, COPD or other lung conditions			
Seizures			
Dizziness			
Head injury			
Vision problems			
Hearing or speech problems			
Chronic disease (please specify)			
Other issues not yet mentioned:			

Any mental health issues, symptoms or concerns?	Past	Current	Comments:
Depression or grief			
Anxiety			
Mood concerns, bipolar disorder			
Attention problems			
Cognitive, learning or reading problems			
Eating problem - restricting, purging or overeating			
Significant fear, paranoia, phobias			
Angry outbursts			
Impulsive or reckless actions			
Strange or intrusive thoughts			
Professionally diagnosed chronic MH condition			
Other issues not yet mentioned:			

How long ago was your last medical exam?:

Current Medication(s) and the condition(s) for which they are prescribed:

Do you take your medications as prescribed? Yes or No
Are your medications effective? Yes or No

Do you have any medication allergies, or have you ever had any adverse reactions to medications? If yes please explain:

Have you ever felt the need to cut down on your drinking or drug use? Yes or No
Have you ever felt annoyed by criticism or your drinking or drug use? Yes or No
Have you ever felt guilty about your drinking or drug use? Yes or No

Have you had treatment for substance abuse, addiction including gambling? If yes please explain:

Are you currently involved in, considering or anticipating involvement in any legal proceedings or lawsuits? If yes please explain:

Do you have any spiritual beliefs that are important for your counselor to be aware of? If yes please explain:

How would you describe your race and/or ethnicity? (optional)

Are there cultural elements to your family or background that are important for your counselor to be aware of? If yes please explain:

What is the highest grade-level or educational degree you have completed?

What do you consider to be your occupation?

Have you had any difficulties with unemployment or professional satisfaction? If yes please explain:

If you are a veteran, do you have concerns that are related to your military experience?

Who currently lives in your household?:

Client Information Form for: ____________________________

Do you have any family history of mental health or substance use/abuse concerns? Is yes please specify:

Have you experienced any significant events such as abuse, neglect, a family-member's illness or death, parental conflict, separation or divorce?

Who would you list among your closest relationships? (e.g. family member, friend, coworker etc.):

Are there ways you get support in your community (for example: church, activities groups etc.)? If yes, please specify:

What are your goals or desired outcomes for counseling?

Your email address: ______________________________@________________________________

Emergency Contact Name and their relation: ____

phone number ____

***This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.*