Body Mind and Spirit Counseling & Wellness Center LLC
8738 Quarters Lake Rd. Bldg #5
Baton Rouge, LA 70809
225-276-6982
Email: bodymindspirit@cox.net

NEW CLIENT BACKGROUND

	First	Middle	Last
Name:			

Date of Birth: * (MM/DD/YYYY)

Gender: * ☐ Male ☐ Female ☐ Other

Blood Group:

Language:

Race:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Employment Status:
- ☐ Employed
- ☐ Full-Time Student
- ☐ Part-Time Student
- ☐ Unemployed
- ☐ Retired

Marital Status: ☐ Single ☐ Married ☐ Other

Primary Contact Details

Caregiver First Name:

Caregiver Last Name:

Email:

Home Phone: (xxx) xxx-xxxx

Mobile Phone: (xxx) xxx-xxxx

Work Phone / Extn: (xxx) xxx-xxxx / xxxx

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Primary Phone:	☐ Mobile Phone	☐ Work Phone	☐ Home Phone

Address Line 1: *	
Address Line 2: *	
City/State/Zip: *	
Postbox No:	

Emergency Contact Name:	
Emergency Contact Number / Extn:	(xxx) xxx-xxxx / xxxx

Primary Insurance Details

Insurance Type: *

- ☐ MEDICARE
- ☐ MEDICAID
- ☐ TRICARE CHAMPUS
- ☐ CHAMPVA
- ☐ GROUP HEALTH PLAN
- ☐ FECA BLK LUNG
- ☐ OTHER _____

Insurance Plan Name or Program Name:	
ID: *	
Insurance Company Name (Payer Name):*	
Payer ID: *	
Payer Address	
Payer City/State/Zip	

Valid From:	MM/DD/YYYY
Valid Until:	MM/DD/YYYY

Copay:	
Deductible:	
Employer/School Name:	
Comments:	

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Insured Person Details

Client Relationship: *	☐ Self	☐ Spouse		
	☐ Child	☐ Other		
First Name: *				
Last Name: *				
Date of Birth: *		(MM/DD/YYYY)		
Gender: *	☐ Male	☐ Female	☐ Other	
Address Line 1: *				
Address Line 2: *				
City/State/Zip: *				
Postbox No:				
Home Phone:		(xxx) xxx-xxxx		
Mobile Phone:		(xxx) xxx-xxxx		

HEALTH AND WELLNESS

Primary Care Physician: *	
Medical and Mental Health Conditions (N/A or list each condition, with medical dosages):*	
Supplements (N/A or list the name and dosages of each):*	
Allergic or adverse reactions to any type of medication (N/A or List):*	
Previous mental health treatment (N/A or list previous providers):*	

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Recent significant life changes or stressful events (N/A or describe): *

Check any symptoms you have experienced in the last TWO WEEKS:*

- ☐ Fatigue
- ☐ Sadness
- ☐ Anger
- ☐ Feeling Overwhelmed
- ☐ Grief
- ☐ Apathy/Loss of Interest in Activities
- ☐ Isolating/Avoiding people
- ☐ Worry/Anxiety
- ☐ Habitual/Compulsive Behavior
- ☐ Social Anxiety
- ☐ Eating Disorder (past or present)
- ☐ Trouble Falling Asleep
- ☐ Appetite – Eating more
- ☐ Others _____
- ☐ Crying Spells/Tearfulness
- ☐ Irritability
- ☐ Easily Frustrated
- ☐ Depressed Mood
- ☐ Difficulty Concentrating
- ☐ Feeling Hopeless
- ☐ Suicidal Thoughts
- ☐ Panic Attacks
- ☐ Fears/Phobias
- ☐ Traumatic Event (within last year)
- ☐ Sleep Disturbance
- ☐ Trouble Staying Asleep
- ☐ Appetite – Eating more

Recent changes in weight (N/A) or list how much):*

SLEEP (estimated average):*

- ☐ 3 hrs or less/night
- ☐ 7-8 hrs/night
- ☐ greater than 10 hrs/night
- ☐ 4-6 hrs/night
- ☐ 9-10 hrs/night

EXERCISE (N/A or describe):*

CAFFEINE USE (N/A or describe):*

ALCOHOL USE:*

- ☐ Never
- ☐ 1-2 days/wk
- ☐ 5 or more days/wk
- ☐ Rarely
- ☐ 3-4 days/wk

SMOKING USE:*

- ☐ Never
- ☐ Occasionally smoke ½ pack/day or less
- ☐ Currently smoking more than a pack a day
- ☐ Former smoker
- ☐ Currently smoking about a pack a day

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SUBSTANCE USE:*	☐ Never	☐ Former
	☐ Current (describe below)	
Current Substance Use (N/A or list):*		
Current Employment (Describe):*		
Primary concerns and goals for therapy:*		

FAMILY MEDICAL HISTORY

Mother's Name:		
Is your mother living?*	☐ Yes	☐ No
Current age or age at passing & cause:		
Mother's Conditions:	☐ Diabetic	☐ COPD/Asthma
	☐ Cancer	☐ Stomach Problems
	☐ Stroke	☐ Heart Disease
	☐ Hypertension	☐ Kidney Disease
	☐ Thyroid	☐ Vision Problems
	☐ Liver Disease	☐ Depression/Mental Illness
	☐ Drug Alcohol Dependence	
	☐ Others _____	

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Father's Name:		
Is your father living?*	☐ Yes	☐ No
Current age or age at passing & cause:		
Father's Conditions:	☐ Diabetic	☐ COPD/Asthma
	☐ Cancer	☐ Stomach Problems
	☐ Stroke	☐ Heart Disease
	☐ Hypertension	☐ Kidney Disease
	☐ Thyroid	☐ Vision Problems
	☐ Liver Disease	☐ Depression/Mental Illness
	☐ Drug Alcohol Dependence	
	☐ Others _____	

Do you have any siblings:*	☐ Yes	☐ No
If yes, list age and relationship of each:		
Sibling Conditions:	☐ Diabetic	☐ COPD/Asthma
	☐ Cancer	☐ Stomach Problems
	☐ Stroke	☐ Heart Disease
	☐ Hypertension	☐ Kidney Disease
	☐ Thyroid	☐ Vision Problems
	☐ Liver Disease	☐ Depression/Mental Illness
	☐ Drug Alcohol Dependence	
	☐ Others _____	

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FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided. You can indicate any additional family mental health history in the space provided next to "Other".

Alcohol/Substance abuse:	
Anxiety:	
Depression:	
Domestic Violence:	
Eating-Disorders:	
Obesity:	
Obsessive Compulsive Disorder:	
Schizophrenia:	
Suicide Attempts:	
Learning Disorders:	
ADHD/ADD:	
Other:	