Lindsay Simon, LMFT

Counseling Intake Form

Name: _____ **Date:** _____ **Gender:** ☐ **Male** ☐ **Female**

Email: _____ **Home Phone:** _____ **Cell/Work:** _____

Home Address: _____ **Date of Birth:** _____

Mailing Address (if different from home)**:** _____

1. **Marital Status:** ☐Married ☐Cohabitating ☐Single ☐Divorced ☐Separated ☐Widowed

2. **Race/Ethnicity:** ☐Caucasian/non-Hispanic ☐Native American ☐African American

   ☐Asian/Pacific Islander ☐Hispanic ☐Middle Eastern ☐Other _____

3. **Education: Please check and circle highest level of education:**

   ☐**Elementary:** K 1 2 3 4 5 6 7 8 ☐**High School:** 9 10 11 12 ☐**College:** 1 2 3 4
   ☐**Graduate School:** 1 2 3 4 5+ ☐**Other** _____

4. **Occupation:**_____

5. **Disability Status**: ☐N/A ☐Temporary ☐Permanent **Type:** ☐N/A ☐Physical ☐Mental

6. **Have you ever received outpatient counseling/psychotherapy services?**
   ☐**Yes** ☐**No** **If yes, When and Where?** _____

7. **Are you currently seeing a psychiatrist?**
   ☐**Yes** ☐**No** **If yes, Who and Where?** _____

8. **Have you ever been hospitalized for psychiatric/mental health reasons?**
   ☐**Yes** ☐**No** **If yes, When and Where?** _____

9. **Have you ever had thoughts of harming yourself or someone else?**
   ☐**Yes** ☐**No** **If yes, When?** _____

10. **Have you ever attempted suicide or severely hurt yourself or someone else?**
    ☐**Yes** ☐**No** **If yes, When?** _____

11. **Do you feel like seriously harming yourself or someone else today?** ☐ **Yes** ☐ **No**

12. **Please list medications, vitamins, & supplements you are taking:**

Medication or Vitamin/supplements	Dosage Frequency	Prescribed For	Prescribing Doctor or Institution	When began medication

13. Please check the problems or concerns that you would like help with in therapy

1. ☐ Academic concerns	21. ☐ Feeling doomed or helpless	39. ☐ Premarital Preparation
2. ☐ Addictions	22. ☐ Financial concerns	40. ☐ Procrastination
3. ☐ ADHD/learning problems	23. ☐ Flashbacks/Nightmares	41. ☐ Relationship concerns
4. ☐ Adjustment to new situation	24. ☐ Identity/sense of self	42. ☐ Self-Esteem
5. ☐ Alcohol or drug concerns	25. ☐ Impulse control	43. ☐ Sexual abuse or assault
6. ☐ Anger management	26. ☐ Intimate relationship concerns	44. ☐ Sexuality concerns
7. ☐ Anxiety, fear, nervousness	27. ☐ Lack of Motivation	45. ☐ Sexual dysfunction
8. ☐ Bullying/Intimidation	28. ☐ Legal concerns	46. ☐ Shyness
9. ☐ Career/job concerns	29. ☐ Loneliness/lack of support	47. ☐ Sleep difficulties
10. ☐ Caregiver stress	30. ☐ Loss, grief, death	48. ☐ Spiritual or religious concerns
11. ☐ Compulsive Behavior	31. ☐ Medical or health concerns	49. ☐ Stress or tension
12. ☐ Concentration difficulties	32. ☐ Mood swings	50. ☐ Thinking about suicide
13. ☐ Concern with other's well-being	33. ☐ Panic Attacks	51. ☐ Racing/Obsessive thoughts
14. ☐ Cultural/multicultural concerns	34. ☐ Paranoia	52. ☐ Trauma
15. ☐ Cutting or self injury	35. ☐ Parenting/Parent-child concerns	53. ☐ Trouble making decisions or getting things done
16. ☐ Depression, sadness	36. ☐ Phase of life problems	54. ☐ Weight concerns
17. ☐ Divorce/Separation	37. ☐ Phobias/specific fears	55. ☐ Other presenting concern
18. ☐ Eating concerns/body image	38. ☐ Physical abuse or assault	_____
19. ☐ Emotional/psychological abuse		
20. ☐ Family problems		

14. Please rank these concerns below from A-most important to C-least important and rate the severity of each one according to the scale below:

1---------2---------3---------4---------5---------6--------7---------8---------9---------10

Not a Problem Mild Problem Moderate Problem Severe Problem Couldn't be worse

A._____ **Rate** _____

B._____ **Rate** _____

C._____ **Rate** _____

15. Now thinking about the past 30 days, how many days did these concerns keep you from doing your usual activities, such as self-care, work/school, interaction with friends/loved ones, or recreation? _____

16. How much do your concerns interfere with your: (use scale below)

Low Interference: 1-----2-----3-----4-----5: Severe Interference

Work/Academic Performance:……..Low: ☐1 ☐2 ☐3 ☐4 ☐5: Severe

Emotional Well-being:……...Low: ☐1 ☐2 ☐3 ☐4 ☐5: Severe

Social Relationships/Activities:……Low: ☐1 ☐2 ☐3 ☐4 ☐5: Severe

Daily Routine:……..Low: ☐1 ☐2 ☐3 ☐4 ☐5: Severe

17. How much caffeine (i.e. coffee, colas, energy drinks) do you drink each day on average?
☐None/very little ☐12-24oz or 1-2 cups ☐25-60oz or 3-5 cups ☐More than 60oz or 5+cups

18. How many alcoholic beverages (beer, wine, or liquor) do you drink per week on average?
_____

19. When was the last time you had more than (4 drinks-women) or (5 drinks-men) in one day?
☐This week ☐This month ☐In the past year ☐More than a year ago ☐Never

20. Do you currently smoke cigarettes? ☐Yes ☐No

If "yes", how many cigarettes do you smoke per day? _____

21. In addition to the substances mentioned above, have you used any drug including marijuana and prescription drugs in the <u>past 30 days</u> that was not prescribed by a doctor or used a prescribed medication in excess of directed dosage?
☐Yes ☐No If yes, What? _____

22. Please check the boxes for the drugs you have ever used.

Drug	Age First Use	Age Last Use	Drug	Age First Use	Age Last Use
☐**Marijuana**			☐**LSD/Acid**		
☐**Cocaine (Coke, Crack)**			☐**Solvents (glue, paint, aerosols)**		
☐**Ecstasy**			☐**Mushrooms**		
☐**Amphetamines (Meth, speed)**			☐**Prescription Drugs (Valium, Ativan, Etc.)**		
☐**Heroin/Opium**			☐**PCP**		

23. On a scale where "100" is "perfect health" and "1" is "near death", rate your current health:_____

24. Name of primary care physician: _____

25. Date of last physical exam: _____

26. Please list any medical condition(s) you are being treated for: _____

27. Are you in pain? ☐No ☐Yes **If yes, Pain Level**: 0 1 2 3 4 5 6 7 8 9 10

If yes, location of pain: _____

28. How would you rate your sleep? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

29. How often do you eat sweet foods, snacks, or junk food?

☐More than once a day ☐Almost Daily/Daily ☐A few times a week ☐Once a week or less

30. On average, how many days per week do you exercise for 30 minutes or more?

0 1 2 3 4 5 6 7 Type of Exercise: _____

31. Please list anyone living in your home (i.e. children, partner, mother, father) and immediate family living or not living in the home (i.e. partner, children):

Name	Relationship	Age	Living in the home
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No

32. Family History, mark the box for conditions or experiences had by your family members (select all that apply):

	Mother	Father	Siblings	Aunt	Uncle	Grandparents
Alcohol or Substance Abuse						
History of Completed Suicide						
Current/History of Mental Illness Psychosocial problems such as:						
Depression						
Anxiety						
Bipolar Disorder						
Schizophrenia						
Attention Deficit/Hyperactivity						
Divorce or Marital Problems						
Victim or Perpetrator of Physical or Sexual Abuse						
Physical Illness or Disability						
Financial or Legal Problems						
Other_____						

Additional Comments:

33. In general how happy were you growing up?

☐Not at all ☐Not Very ☐Somewhat ☐Very ☐Completely

34. I get the emotional help and support I need from my family and friends.

☐Very Strongly Disagree ☐Strongly Disagree ☐Mildly Disagree ☐Neutral
☐Mildly Agree ☐Strongly Agree ☐Very Strongly Agree

35. Who or What are major supports in your life:

☐Parent(s)	☐Friend(s)	☐Partner	☐Sibling(s)
☐Child(ren)	☐Relatives	☐Professional Caregiver	☐Pet(s)
☐Religious/Spiritual Community	☐Sports/Clubs/Social Organizations	☐Support Group/12 Step	☐Nobody

36. Would you like to integrate your religion/spirituality into treatment?

☐Yes ☐No ☐N/A ☐Possibly, How: _____

37. Would you like to integrate your cultural traditions or practices into treatment?

☐Yes ☐No ☐N/A ☐Possibly, How: _____

38. Would you like to integrate alternative healing practices or beliefs into treatment?

☐Yes ☐No ☐N/A ☐Possibly, How: _____

39. Below are eight statements with which you may agree or disagree. To the right of each statement, mark the box that indicates how much you have agreed or disagreed with each statement over **the last four weeks.**

Using the 1–7 scale, indicate your agreement with each item by marking the box that best reflects your opinion for each statement.	**1** **Strongly Disagree**	**2** **Disagree**	**3** **Slightly Disagree**	**4** **Neither Agree or Disagree**	**5** **Slightly Agree**	**6** **Agree**	**7** **Strongly Agree**
I lead a purposeful and meaningful life							
My social relationships are supportive and rewarding							
I am engaged and interested in my daily activities							
I actively contribute to the happiness and well-being of others							
I am competent and capable in the activities that are important to me							
I am a good person and live a good life							
I am optimistic about my future							
People respect me							

40. How did you hear about counseling with Lindsay Simon, LMFT?

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