

DEBORAH OWENS, LPC, CAADC, CEAP

Intake: Please provide the following information.

Note: information you provide here is protected as confidential information.

Name: _____
(Last) (First) (Middle Initial)

Birth Date: _____ / _____ / _____

Address: _____
(Street and Number)

(City) (State) (Zip)

Home Phone: _____ May I leave a message? Yes No

Cell/Other Phone: _____ May I leave a VM or text message? Yes No

E-mail: _____ May I email you? Yes No

*Please note: Email correspondence and texts are not considered to be a confidential medium of communication.

Referred by (if any): _____

Single Cohabiting/Domestic Partnership Married Separated Divorced Widowed

Any children/ages: _____

Are you currently in a committed or romantic relationship? No Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

Describe any issues _____

Have you previously received any type of mental health services (psychotherapy, psychiatric help, counseling, etc.)?

No Yes, previous therapist/practitioner: _____

Describe that process and if it was helpful: _____

Are you currently taking any prescription medication?

Yes

No

Please list medication(s) & who's prescribing it: _____

Have you ever been prescribed psychiatric medication?

- Yes
- No

Please list and provide dates:

How would you rate your current physical health? (please circle)

Poor Unsatifactory Satisfactory Good Very good

Please list any specific health problems you have had or are currently experiencing:

Rate your current sleeping habits (please circle)

Poor Unsatifactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

What types of hobbies, interests, or exercise, if any, do you participate in?:

Please describe any difficulties you experience with your appetite or eating patterns:

Are you currently experiencing sadness, grief or depression?

- No
- Yes

If yes, for approximately how long? _____

Describe _____

Have you had or are you currently having thoughts of harming yourself?

Describe: _____

Have you had any suicide attempts?

- No
- Yes: describe dates and circumstances: _____

Are you currently experiencing anxiety, panic attacks or have any fears or phobias?

- No
- Yes

If yes, when did you begin experiencing this? _____

Describe: _____

Are you currently experiencing any chronic pain?

- No
- Yes

If yes, describe _____

Have you ever felt you needed to cut down on your alcohol or drug use? Yes No

Have some people criticized your use or shared concerns about it? Yes No

Have you felt guilty, worried, or stressed about your drinking or drug use? Yes No

Describe any related details or concerns:

Describe any other types of addictive type (internet, gambling, sex, substances) behaviors?

What significant life changes or stressful events have you experienced?

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a *family history* of any of the following.
If yes, please describe and indicate their relationship to you in the space provided (father, grandmother, uncle, etc.). Please Circle, List Family Member

Alcohol/Substance Abuse yes/no _____

Anxiety yes/no _____

Depression yes/no _____

Domestic Violence/Abuse yes/no _____

Eating Disorders yes/no _____

Schizophrenia yes/no _____

Suicide/ Attempts yes/no _____

Obsessive Compulsive Behavior yes/no _____

Other? _____

ADDITIONAL INFO:

Are you currently employed or in school? No Yes

What is your current situation?:

Do you enjoy your work? Is there anything stressful about your current work?

Do you consider yourself to be spiritual or religious? No Yes

If yes, describe your faith or belief:

What do you consider to be some of your strengths or areas in your life that are going well?

What do you consider to be some of the areas you need to improve?

What would you like to accomplish out of your time in therapy?

Is there anything else I should know about you, your history, or your current situation or what brings you here today?

Signature/date
