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I am interested in an appointment in:
Upper St. Clair Office: ____Murrysville Office: ____

COUNSELING INTAKE FORM

Name:	Today's Date:
Date of Birth:	Relationship Status:
Age:	SSN:
# of Dependents:	Gender: M / F
Home/Mobile Phone:	Is it ok to leave a message for you at this number? Y / N
Work Phone:	Is it ok to leave a message for you at this number? Y / N
Email:	Is it ok to email you? Y / N
Mailing Address:	Fax#: Ok to fax you? Y/N
Current Employer:	Position Title:
Current Occupational Status: (i.e., F/T, P/T, self-employed, student, returning to work):	
How Long on this Job:	Do you enjoy your job:
Education Level:	Special Trainings:
Hobbies:	Military Background:
Talents:	
Emergency Contact Name:	
ER Contact Relationship:	Emergency Contact Phone:
How were you referred?	If online, which website?

Physical Health Data:

Describe your Physical Health: Excellent: ____Good: ____Average____Poor_____Weight:_____Height:____

Are you now under a doctor's care? _____If yes, name of doctor_____

Reason for doctor's care_____

List current medications and reason for taking_____

Hospitalizations and
Reasons:_____

_____

Have you ever been hospitalized for a mental illness?____ Describe_____

Have you ever suffered from an eating disorder, such as bulimia, anorexia or obesity?_____

Rrecent major illnesses or surgeries_____

Family Data:

Where born _____Ethnic ID_____

FATHER: age now if living: _____Age at Death_ _____Cause: _____Your age then:_____

MOTHER: age now if living _____Age at Death _____Cause: _____Your age then:_____

Do your parents live together? Yes _____No_ _____Were Parents Divorced? Yes _____No_____

Do you feel closest to your Mother _____Father _____Neither_____

Your Marital Status_ _____#of marriages _____Spouse's Name_____

Living with a partner _____How long _____Partner's Name_____

CHILDREN:#1 M F Age_____ #2 M F Age_____ #3 M F Age_____#4 M F Age____#5 M F Age_____

SIBLINGS: Circle your place in the family. If a sibling is deceased, put an X through the placement number.

#1 M F Age____ #2 M F Age____ #3M F Age____ #4 M F Age____ #5 M F Age____ #6 M F Age_____

Family Alcoholism or Domestic Violence?_____ Sexual Addictions or Abuse?_____

Parents divorced? _____If yes, what year_ _____Your age at the time_____

If deceased, what year? _____Your age at the time_ _____Cause of death_____

Any step-parents? _____If yes, describe when and your relationship with them_____

_____

If raised by someone other than your birth parents, describe:_____

_____

Legal Data:

Have you ever been incarcerated (Jail or Prison)? Yes _____No_ _____Dates_____

Reason_____Where_____

Have you ever had a DWI (Driving While Intoxicated)? Yes _____No_____How Many:_____

Are you currently on Probation? Yes _____No_____Explain_____

Religious Data:

Current Religious Preference:_____

In Childhood:_____

Emotional Data:

Describe your life now: Happy _____Unhappy _____Situational Stress_____ Anxious_____

Depressed _____In Conflict _____Suicidal Thoughts _____List previous therapies or counseling for personal, emotional or marital problems:

Dates:	Problem:	Type of Treatment:	Therapist:

Chemical Dependency Data:

Have you ever been in treatment for Chemical Dependency/Addiction? Yes_____No_____

If Yes, Where:_____

Treatment was for what chemical: _____Are you involved in a recovery program? Yes _____No_____ Do you attend meetings? Yes ____No ____Have you completed a 12-step program? Yes ____No _____When _____Do you have a sponsor? Yes_____ No_____

Behavior – check any of the following behaviors that apply to you:

☐ Overeat	☐ Suicidal attempts	☐ Can't keep a job	☐ Take drugs	☐ Compulsions
☐ Insomnia	☐ Vomiting	☐ Smoke	☐ Take too many risks	☐ Odd behavior
☐ Withdrawal	☐ Lack of motivation	☐ Drink too much	☐ Nervous tics	☐ Eating problems
☐ Work too hard	☐ Procrastination	☐ Sleep disturbance	☐ Crying	☐ Impulsive reactions
☐ Phobic avoidance	☐ Outbursts of temper	☐ Loss of control	☐ Aggressive behavior	☐ Concentration difficulties

Feelings – check any of the following feelings that apply to you:

☐ Angry	☐ Guilty	☐ Unhappy	☐ Annoyed	☐ Happy	☐ Bored
☐ Conflicted	☐ Restless	☐ Depressed	☐ Regretful	☐ Lonely	☐ Anxious
☐ Contented	☐ Fearful	☐ Hopeful	☐ Excited	☐ Panicky	☐ Helpless
☐ Energetic	☐ Relaxed	☐ Tense	☐ Envious	☐ Jealous	☐ Others:

Physical – check any of the following symptoms that apply to you:

☐ Headaches	☐ Stomach trouble	☐ Skin problems	☐ Dizziness	☐ Tics
☐ Dry mouth	☐ Palpitations	☐ Fatigue	☐ Burning or itchy skin	☐ Muscle spasms
☐ Twitches	☐ Chest pains	☐ Tension	☐ Back pain	☐ Rapid heart beat
☐ Sexual disturbances	☐ Tremors	☐ Unable to relax	☐ Fainting spells	☐ Blackouts
☐ Bowel disturbances	☐ Hear things	☐ Excessive sweating	☐ Tingling	☐ Watery eyes
☐ Visual disturbances	☐ Numbness	☐ Flushes	☐ Hearing problems	☐ Don't like being touched

Check any of the following that apply to you:

	Never	Rare	Frequent	Often		Never	Rare	Frequent	Often
Marijuana					Heart problems				
Tranquilizers					Nausea				
Sedatives					Vomiting				
Aspirin					Insomnia				
Cocaine					Headaches				
Painkillers					Backaches				
Alcohol					Early morning awakening				
Coffee					Fitful sleep				
Cigarettes					Binge / Purge				
Narcotics					Poor appetite				
Stimulants					Eat "junk foods"				
Hallucinogens					Lack of interest in activities				
Diarrhea					Constipation				
Compulsive Exercise					High blood pressure				
Use Laxatives					Allergies				

List 3 Strengths you believe you have:

1._____

2._____

3._____

List 3 Weaknesses you believe you have:

1._____

2._____

3._____

List 3 Support Systems you have in your life right now:

1._____

2._____

3._____

List 3 Issues or Problems that you want to address now and obtain help with:

1._____

2._____

3._____

Personal Agreements

I have read and signed the Telemedicine Consent Form OR Informed Consent and General Policy Forms, and have had the opportunity to ask any questions. (Please return these by FAX or bring with you to your appointment.

I understand that I may be asked to do certain "homework exercises" such as reading, journaling, changing behaviors, and otherwise acting in my own best interest. I understand that I am entirely responsible for my own actions and I will always make my own final decisions regarding counseling and the work I complete.

I further understand that much of the work done will be to resolve issues and will depend on my honesty, and willingness to do the things I need to do to move forward even if it is painful and difficult.

I understand that whatever I say in a session is strictly confidential and will not be released to anyone without my consent unless I am violating codes of abuse, harm to myself or others.

I agree to pay for all services rendered.

I understand that I will pay in full for appointments not cancelled with 24 hours notice.

_____(client signature and date)

A Personal Note from Dr. Lynne . . . The love of people is what called me into this profession. I have had the privilege of working with thousands of individuals, and hope to provide you with the best professional services available. I am committed to regularly advance my clinical education to further my knowledge in the ever expanding field of mental health. My compassion and empathy for those who suffer emotionally, combined with my clinical experience and trainings are what I hope will make a difference in the quality of your life and relationships. And no matter what you may be going through in your life right now, the one thing I want to offer you is hope.