LIGHTHOUSE COUNSELING SERVICES **Lighting your path**
www.lighthousecounselors.com ***to a better life . . .***

INTAKE FORM

TO THE PATIENT: Your responses to the following questions will help your therapist better understand you and your situation in order to provide the best possible treatment. Please answer all questions as completely as possible. If you need additional room, please use the reverse side.

IDENTIFYING INFORMATION

Name of person completing this form:_____ Referral source:_____

Name of the identified patient:_____

D.O.B.:_____ Age:_____ Gender: F M O Social Security#:_____-_____-_____

Address:_____City_____Zip_____

Cell Phone:_____ Other Phone_____ May we leave a message? Y N

Email address:_____May we reach you via text message? Y N

Grade (if in school): _____ Race/Ethnicity:_____ Religion:_____

Relationship status: (please circle all applicable): Single /Dating /Engaged/ Married/ Partnered/ Separated/ Divorced/ Widowed

Emergency Contact:_____ Phone:_____ Relationship:_____

*****If you feel your therapist should be aware of any special considerations due to safety, gender, age, sexual orientation, or cultural, religious, national, racial or ethical identity, please explain here:**

_____

<u>INSURANCE INFORMATION</u> (This section must be completed in order for your therapist to bill your insurance.)

Primary Insurance _____

Policy holder's name _____Relationship to patient_____

Policy holder's DOB _____Policy Holder's Phone Number_____

Policy holder's Address _____

Member ID _____ Group ID_____ Policy Holder's Employer _____

Secondary Insurance (if applicable) _____

Policy holder's name _____Relationship to patient_____

Policy holder's DOB _____Policy Holder's Phone Number_____

Policy holder's Address _____

Member ID _____ Group ID_____ Policy Holder's Employer _____

PRESENTING PROBLEMS- Current Situation & History

1. **Why is the patient seeking counseling/therapy?**

_____

_____

2. **When did the problems begin?**_____

3. **How has it changed over time?**

_____

4. **Have you ever received treatment for this or other problems in the past? YES NO**

   If YES, when, where, and with whom? Please include psychiatric hospitalizations.

   _____

5. **Are you feeling suicidal today (circle one)? YES NO I'M NOT SURE**

6. **Please share the behaviors/symptoms that occur and/or have occurred for the patient. (Please mark with an X all that apply.)**

Symptom/Behavior	Now	In the Past	Symptom/Behavior	Now	In the Past
Aggressions			Judgment Errors		
Alcohol Abuse			Learning Problems		
Anxiety/Worry			Attention Problems		
Avoiding People			Loneliness		
Chest Pain			Memory Problems		
Depression			Mood Shifts		
Disorientation			Panic Attacks		
Distractibility			Phobias/Fears		
Dizziness			Intrusive Thoughts		
Drug Abuse/Dependence			Sexual Difficulties		
Eating Issues			Frequent Illness		
Elevated Mood			Speech Problems		
Fatigue			Sleep Problems		
Hallucinations			Suicidal Thoughts		
Heart Palpitations			Homicidal Thoughts		
High Blood Pressure			Headache/Migraines		
Hopelessness			Restlessness		
Impulsivity			Self-Injury/Self-harm		
Irritability			Stomach Problems		
Chronic Pain			Digestive Issues		
Sensory Sensitivity			Excessive masturbation		
In utero alcohol/drug exposure			Excessive sweating		
Opposition/Defiance			Suicide attempts	NA	
Legal Problems			Gambling Addiction		
Bankruptcy			Sexual Addiction		
Grief/Bereavement					

7. Do you drink alcohol or use other substances? YES NO

If yes, how many times and how much each day _____ week **_____ month_____?**

If yes, please indicate types.

Alcohol Cigarettes Marijuana Opiates Other _____

8. How many hours per day do you spend looking at a screen for school/work _____ for leisure_____?

9. Have you experienced (circle all that apply): Bullying Emotional Abuse Sexual Abuse Physical Abuse

10. Have you or has anyone in your family had contact with Child Protective Services? YES NO

11. Please share the patient's significant life events and/or traumatic events. Include accidents, serious illnesses, divorce, relocations, job losses, marriages, arrests/incarcerations and anything else you deem significant.

Event	Age	Event	Age

FAMILY HISTORY

1. Who raised/is raising the patient? _____

2. Is the patient adopted? YES NO 3. Has the patient been previously in out-of-home placements? YES NO

4. Does anyone in the patient's family have any history of the following? (Please mark all that apply & state relationship to patient.)

Problem	X	Relationship	Problem	X	Relationship
Addiction Problems			Physical/Emotional/Sexual Abuse		
Major depression			Bipolar Disorder		
Alcohol/Drug Abuse			ADD/ADHD		
Anxiety/Panic			Suicide (Attempted or Completed)		
Bankruptcy			Anger Problems		
Arrest/Incarceration/Probation			Personality Changes		
Other:			Other:		

5. Who lives with the patient on a regular basis? Please indicate name/age/relationship.

Name	Age	Relationship	Do you need a referral for him/her?

MEDICAL HISTORY

1. **Name of Primary Care Physician: _____ PCP Phone Number_____**

2. **Describe the patient's medical conditions (past/present).**

_____

_____

3. **What date (month/year) was the patient's last physical exam? _____**

3. **What medications and/or vitamins/supplements does the patient take?**

Name	Dosage	What Does it Treat	Physician/Psychiatrist Name

4. **Please list all psychiatric and medical hospitalizations, surgeries and injuries (including broken bones):**

_____

5. **Describe the patient's developmental history.**

Was there anything unusual about the patient's time in utero or the patient's birth? YES NO

If yes, explain. _____

Did the patient experience delays/challenges in any of the following areas (circle all that apply)?

Physical Development Emotional Development Verbal Development Social Development

6. **How many hours of sleep on average does the patient get each night? _____**

7. **How many hours per week does the client engage in self-care (e.g. yoga, exercise, hobbies)? _____**

ADDITIONAL INFORMATION

SCHOOL/ WORK INFORMATION:

1. **Where does patient work or go to school?_____**
2. **What is the highest level of education completed? _____Where? _____ When?_____**
3. **If employed, what does the patient do for work?_____**
4. **Are there any current problems for the patient in the school/workplace setting? Please specify.**

_____

_____

SOCIAL RELATIONSHIPS/FRIENDS

1. **Please list other significant people in the person's life, including name and relationship.**

   _____

   _____

   _____

2. **How does the patient get along with peers/coworkers?**

   _____

3. **Has the patient ever experienced the loss of a loved one, close friend or other significant relationship through death, divorce, separation or other reason? Please describe.**

   _____

   _____

STRENGTHS/LIMITATIONS

1. **Please describe the patient's strengths:**

   _____

   _____

2. **Please describe the patient's limitations:**

   _____

   _____

COUNSELING/THERAPY GOALS

What changes would you like to see as a result of counseling/therapy? Please list three changes, beginning with the most important to you:

1. _____

   _____

2. _____

   _____

3. _____

   _____

I certify that all of the above information is true to the best of my knowledge.

_____

Patient Signature (ages 14 and up) **Date**

_____

Parent/Guardian Signature (if a minor under age 18) **Date**

_____

Therapist Signature **Date**