Life Script Mental Health Counseling Services PLLC

"Helping You Reclaim Your Life"

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Civilian/Military Version

INTAKE FORM

PERSONAL DATA

Date: _____ Birth Place: _____

Name: _____ Age: _____ Birth Date: _____

Street: _____ Home Phone #: _____

City: _____ Mobile: _____

State: _____ Zip: _____ E-Mail: _____

EMPLOYMENT DATA

Employer: _____ Job Title: _____

Street: _____ Years Employed: _____

City: _____ Work Phone #: _____

State: _____ Zip: _____

EMERGENCY CONTACT INFORMATION

Name of person to contact: _____ Phone #: _____

Relationship to you: _____

EDUCATIONAL DATA

Highest Grade Completed: 9 10 11 12 AAS BA/BS MASTERS PhD

Degrees:_____

IF YOU ARE CURRENTLY A STUDENT:

School Name: _____

Street: _____

City:_____

State: _____ Zip: _____

Insurance (Does not apply to Medicade/Medicare):

Does your insurance plan have out of network coverage? Yes No Not Sure

If you are not certain about the coverage, please find out and let me know. If you have out of network coverage I will provide a super bill that you can submit to your insurance company so they may reimburse you.

EAP Referrals Only

Name of Health Plan: _____ Provider Name: _____

Provider Phone number: _____

MARTIAL STATUS:

Single/Not Married _____ Never Married _____

Married:_____ How Long:_____ Single w/Partner_____ How Long?_____

Partner's Name_____ Age:_____ Partner's Employer:_____

Separated:_____ Divorced:_____ Widowed: _____ How Long:_____

Ex-spouse's Name_____

CHILDREN (First Name Only) Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

MEDICAL

Primary Care Physician (PCP)

Name:_____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Date of last physical: _____ May I contact Your PCP? Yes___ No___ Initials: _____

List names of any other physicians you are currently seeing, and the condition they are treating you for

Name:_____ Address: _____

Condition:_____

Name:_____ Address: _____

Condition:_____

Are you taking any prescription drugs at this time? Yes___ No___

If **YES**, please list name of medication and condition prescribed for:

Medication:_____ Dosage: _____ Condition_____

Medication:_____ Dosage: _____ Condition_____

Medication:_____ Dosage: _____ Condition_____

Medication:_____ Dosage: _____ Condition_____

Do you have any food allergies?	NO	YES	?
Do you have hay fever, mold, or tree/grass/weed pollen allergies?	NO	YES	?
Do you have any other allergies?	NO	YES	?
Would you like to minimize or possibly eliminate these allergies?	NO	YES	?

FAMILY HISTORY

The following information will help me understand you and your relationship(s) to your family. Please fill out those which apply to you .

Father:_____ Age:_____

Year Deceased:_____ Cause of death:_____

Mother:_____ Age:_____

Year Deceased:_____ Cause of death:_____

Step mother:_____ Age:_____

Year Deceased:_____ Cause of death:_____

Step father:_____ Age:_____

Year Deceased:_____ Cause of death:_____

Describe your childhood experience of your father/step father: _____

_____

_____

Describe your childhood experience of your mother/step mother: _____

_____

_____

Number of **Brothers:**_____ Name:_____ Age:_____

Name:_____ Age:_____ Name:_____ Age:_____

Name:_____ Age:_____ Name:_____ Age:_____

Number of **Sisters:**_____ Name:_____ Age:_____

Name:_____ Age:_____ Name:_____ Age:_____

Name:_____ Age:_____ Name:_____ Age:_____

What type of relationship do you have with your siblings? _____

_____

_____

Have any of your brothers or sisters attended counseling before? NO YES ?

Details:_____

_____

Have any of your parents or step parents attended counseling before? NO YES ?

Details:_____

_____

Any history of drug or alcohol abuse in your father's family, including your father? NO YES ?

Details:_____

_____

Any history of drug or alcohol abuse in your mother's family, including your mother? NO YES ?

Details:_____

_____

Any history of drug or alcohol abuse with you? NO YES ?

Details:_____

What made you use or continue to use?_____

_____

Any history of drug or alcohol abuse with your spouse/partner? NO YES ? N/A

Details:_____

_____

Any history of traumatic events experienced by your father or his parents? NO YES ?

Details:_____

_____

Any history of traumatic events experienced by your mother or her parents? NO YES ?

Details:_____

_____

What Religion were you raised in? _____

What spiritual practices do you indulge yourself in? (ex. meditation, yoga, music, art, etc.)

Details:_____

_____

Have you either witnessed or been the victim of any of the following: (Check All That Apply)

- ❒ Sexual abuse or rape? Who was the perpetrator? _____
- ❒ Physical abuse Who was the perpetrator? _____
- ❒ Emotional or mental abuse? Who was the perpetrator? _____
- ❒ Financial Abuse? Who was the perpetrator? _____
- ❒ Spiritual or religious Abuse? Who was the perpetrator? _____
- ❒ Cult or Ritual Abuse? Who was the perpetrator? _____

Did other family members witness any of the abuses checked above? NO YES ? N/A

Details:_____

_____

Were any other family members victims of the abuses checked above? NO YES ? N/A

Details:_____

_____

Were drugs or alcohol involved in the abuse? NO YES ? N/A

How has this experience affected your life?

Details:_____

_____

Any history of physical abuse to your spouse/partner? NO YES ? N/A

Details:_____

_____

Any physical problems that you feel has affected your life? NO YES ?

Details:_____

_____

Any history of sexual abuse to your spouse/partner? NO YES ? N/A

Details:_____

_____

Have you ever experienced any sexual difficulties? NO YES ?

Details:_____

_____

Do you ever feel like someone or something has taken over your body or mind? NO YES ?

If yes, what percentage of the time? _____

Have you ever had counseling before? NO YES How Long:_____

When:_____ Where:_____

Facilitator(s)/Details: _____

Has your spouse/partner ever had counseling before? NO YES How Long:_____

When:_____ Where:_____

Facilitator(s)/Details: _____

Have you ever been a member of a self-help group? No Yes How Long:_____

When:_____ Where:_____

Facilitator(s)/Details: _____

Have you ever suffered a significant loss, such as a:

Job	NO	YES	_____
Family member or other loved one	NO	YES	_____
Abortion	NO	YES	_____
Miscarriage	NO	YES	_____
Have you ever had major surgery?	NO	YES..	_____

Have you ever been in the military/police/fire/EMT/First Responders? NO YES Branch:_____

If **YES**, did you witness or were you a part of any traumatic events in the line of duty?: NO YES

Details:_____

_____

_____

Have you ever been in a serious car accident or other disaster? NO YES

Details:_____

Any particular fears, phobias or anxieties I should be aware of? NO YES

Details:_____

Do you: Smoke? NO YES How many Packs a day? _____

Use Alcohol? NO YES How many drinks per day? _____

Use Illegal drugs? NO YES What type? _____

How much/often? _____

If Yes: Do you want to quit? NO YES ?

List three goals that you want to accomplish as a man or woman in your counseling & growth:

1. _____

2. _____

3. _____

List your last three employers:

1. _____ From:_____ To:_____

Reason For Leaving the above Job: _____

2. _____ From:_____ To:_____

Reason For Leaving the above Job: _____

3. _____ From:_____ To:_____

Reason For Leaving the above Job: _____

ACE Score

Adverse Childhood Experience

Place an X in the Yes or No box for each question

QUESTION:	**YES**	**NO**
Did a parent or other adult in the household **often or very often** swear at you, insult you, humiliate you, or put you down, ***OR*** act in a way that made you afraid that you might be physically hurt?		
Did a parent or other adult in the household **often** or **very often push**, grab, slap, or throw something at you ***OR*** ever hit you so hard that you had marks or were injured?		
Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way, ***OR*** attempt to have anal, oral or vaginal intercourse with you?		
Did you **often or very often** feel that no one in your family loved you or thought you were important or special ***OR*** that your family did not look out for each other or support each other?		
Did you **often or very often** feel that you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you, ***OR*** your parents were too drunk or too high to take care of you or take you to a doctor if you needed it?		
Were your parents ever separated or divorced?		
Was your mother or stepmother **often or very often** pushed, grabbed, slapped or had something thrown at her, ***OR***, sometimes, often or very often kicked, bitten, or hit with a fist or hit with something hard, ***OR***, ever repeatedly hit at least a few minutes or threatened with a gun or a knife?		
Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?		
Was a household member depressed or mentally ill, ***OR*** did a household member commit suicide?		
Did a household member go to prison?		
Total number of YES answers:		

Candida Screening

If your answer to a statement is ***yes*** or ***true***, circle the number after the statement.

Have you taken antibiotics (penicillin, amoxicillin, etc) short term or long term?	4
Do you feel "sick all over," yet the cause hasn't been found?	3
Are you bothered by hormone disturbances, including PMS, menstrual irregularities, sexual dysfunction, sugar craving, low body temperature or fatigue?	2
Are you unusually sensitive to tobacco smoke, perfumes, colognes and other chemical odors?	2
Are you bothered by memory or concentration problems or do you sometimes feel "spaced out"?	2
Have you taken prolonged courses of Prednisone or other steroids; or have you taken "the pill" for more than 3 years?	2
Do some foods disagree with you or trigger your symptoms?	1
Do you suffer with constipation, diarrhea, bloating, or abdominal pain?	1
Does your skin itch, tingle or burn; or is it unusually dry; or are you bothered by rashes?	1
Total Score	

Scoring for women: 9 or greater Probably; 12 or greater most certainly

Scoring for men: 7 or greater Probably; 10 or greater most certainly

Depression Screening: PHQ-9

Answer each of the following questions with regard to how you have felt over the last two weeks.

Circle the number that represents the amount of time you experience the symptom or topic

Symptom or Topic	Not at all	Several Days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping to much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about your self, that you are a failure	0	1	2	3
Trouble concentrating on tasks or activities like reading or watching TV	0	1	2	3
Moving or speaking slowly, or being fidgety & restless	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself or some-one	0	1	2	3
Total each column:				
How difficult have these problems made it for you to work, take care of things at home or get along with others?	Not Difficult	Some-what Difficult	Very Difficult	Ex-tremely Difficult

*These questions are to ask about things you may have felt most days in the **past six months**.*

Most days I feel very nervous.	YES	NO
Most days I worry about lots of things.	YES	NO
Most days I cannot stop worrying	YES	NO
Most days my worry is hard to control.	YES	NO
I feel restless, keyed up or on edge.	YES	NO
I get tired easily.	YES	NO
I have trouble concentrating	YES	NO
I am easily annoyed or irritated.	YES	NO
My muscles are tense and tight.	YES	NO
I have trouble sleeping.	YES	NO
Did the things you noted above affect your daily life (at home, work or leisure) or cause you a lot of distress?	YES	NO
Were the things you noted above bad enough that you thought about getting help for them?	YES	NO

Post Traumatic Stress Disorder Check List

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Use the below scoring to indicate how much you have been bothered by the experience.

1 = Not at all 2 = A little bit 3 = Moderately 4 = Quite a bit 5 = Extremely

1.	Repeated, disturbing memories, thoughts or images of a stressful military/life experience.	1 2 3 4 5
2.	Repeated, disturbing dreams of a stressful military/life experience.	1 2 3 4 5
3.	Suddenly acting or feeling as if a stressful military/life experience were happening again, as if you were reliving it.	1 2 3 4 5
4.	Feeling very upset when something reminded you of a stressful military/life experience	1 2 3 4 5
5.	Having physical reactions (e.g: heart pounding, trouble breathing, sweating) when something reminded you of a stressful military/life experience.	1 2 3 4 5
6.	Avoiding thinking about or talking about a stressful military/life experience or avoiding having feelings related to it.	1 2 3 4 5
7.	Avoiding activities or situations because they remind you of a stressful military/life experiences	1 2 3 4 5
8.	Trouble remembering important parts of a stressful military/life experience.	1 2 3 4 5
9.	Loss of interest in activities that you used enjoy.	1 2 3 4 5
10.	Feeling distant or cut off from other people.	1 2 3 4 5
11.	Feeling emotionally numb or being unable to have loving feelings towards those close to you.	1 2 3 4 5
12.	Feeling as if your future will somehow be cut short	1 2 3 4 5
13.	Trouble falling or staying asleep	1 2 3 4 5
14.	Feeling irritable or having angry outbursts	1 2 3 4 5
15.	Having difficulty concentrating	1 2 3 4 5
16.	Being "super-alert" or watchful or on guard	1 2 3 4 5
17.	Feeling jumpy or easily startled	1 2 3 4 5

Add up the circled numbers in each column:

Total

Scoring: 17 —- None: Less than 22 – Questionable; 22 – 44 Sub Clinical; Greater than 50 — Clinical

Anger Evaluation

1	Are you habitually impatient?	Yes	No
2	Are you often frustrated?	Yes	No
3	Do others seem to constantly be "in your way?	Yes	No
4	Are you usually on your guard against being cheated?	Yes	No
5	Do you feel a more or less constant pressure to prove yourself?	Yes	No
6	Are you habitually fearful of somehow being "caught"?	Yes	No
7	Does it seem (or feel) that someone is always watching you ?	Yes	No
8	Do you secretly resent others' success, feeling that yours is never recognized?	Yes	No
9	Are the negative things in your life more obvious to you than the positive?	Yes	No
10	Do you habitually find a lot to complain about ?	Yes	No
11	Do you often feel insecure, believing that others are superior to you	Yes	No
12	Are you afraid you will end up with less than you need?	Yes	No
13	Do you habitually expect bad things to happen?	Yes	No
14	Is it hard for you to "go with the flow" ?	Yes	No
15	Is it often difficult for you to stand up for yourself?	Yes	No
16	Do you secretly believe that your feelings are not important?	Yes	No
17	Do you usually keep your preferences to yourself, often deferring to what others want?	Yes	No
18	Do you feel your needs are often minimized or ignored altogether?	Yes	No
19	Do you have temper tantrums ?	Yes	No
20	Do you regularly tend to overreact?	Yes	No
21	Is it hard for you to accept that others care about and love you?	Yes	No
22	Are you frequently afraid that somehow you are "missing out" on what counts?	Yes	No
23	Are you often disrespectful to those with less power than yourself ?	Yes	No
24	Does the intimacy of others somehow make you uncomfortable?	Yes	No

Total Number of Yes Answers:		

How did you find out about me?

❒ Personal Referral

Who Referred you? _____

May I send this person a thank you card? YES NO

If YES: Their Address: _____

City: _____ State: _____ Zip: _____

❒ Google Search

❒ Psychology Today Web Site

❒ HelpPro Web Site

❒ ThumbTack

❒ Good Therapy

❒ ACEP Web Site

❒ EFT Universe Web Site

❒ The Tapping Solution/Tapping International Web Site

❒ Veteran's Stress Project

❒ Legends 102.7/WLGZ/Save Our Soldiers

❒ Other Web Site: _____

❒ Some other method: _____

Did you visit my web site before calling me? YES NO

Was my web site helpful in your decision? YES NO