

Life Script Mental Health Counseling Services PLLC

"Helping You Reclaim Your Life"

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INSTRUCTIONS:

You may fill this form out online using one of the following free programs:

SEJDA: <https://www.sejda.com/pdf-editor>

PDF Pro: <https://www.pdfpro.co/>

PDF Escape: <https://www.pdfescape.com/windows/>

Alternatively, you may print it out and fill it in by hand. Once that is done you may:

1. Bring it with you
2. Scan into a PDF file only and return it by email or FAX: 585-787-7478. ***Do not photograph into jpg files.***

Email: info@lifescryptcounseling.com

Thank You!



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 Medicaid/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:_____
- Widowed How Long:_____ Deceased Partner's Name_____
- Single w/Partner How Long?_____ Partner's Name_____ Age:_____
- Separated How Long:_____ Ex-spouse's Name_____
- Divorced How Long:_____ Ex-spouse's Name_____

CHILDREN (First Name Only)

Name: _____ Age: _____ 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 stepparents 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

If yes, what made you use or continue to use?

Details

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 Unknown

Details

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

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

Details

How has this experience affected your life?

Details

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

Details

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 to any of the above: Do you want to quit? NO YES

List three goals that you want to accomplish 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?	c	c
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?	c	c
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?	c	c
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?	c	c
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?	c	c
Were your parents ever separated or divorced?	c	c
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?	c	c
Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	c	c
Was a household member depressed or mentally ill, OR did a household member commit suicide?	c	c
Did a household member go to prison?	c	c
For office use only:		

Candida

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

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

<i>Symptom or Topic</i>	<i>Not at all</i>	<i>Several Days</i>	<i>More than half the days</i>	<i>Nearly every day</i>
Little interest or pleasure in doing things	0 c	1 c	2 c	3 c
Feeling down, depressed, or hopeless	0 c	1 c	2 c	3 c
Trouble falling or staying asleep, or sleeping too much	0 c	1 c	2 c	3 c
Feeling tired or having little energy	0 c	1 c	2 c	3 c
Poor appetite or overeating	0 c	1 c	2 c	3 c
Feeling bad about your self, that you are a failure	0 c	1 c	2 c	3 c
Trouble concentrating on tasks or activities like reading or watching TV	0 c	1 c	2 c	3 c
Moving or speaking slowly, or being fidgety & restless	0 c	1 c	2 c	3 c
Thoughts that you would be better off dead or of hurting yourself or someone	0 c	1 c	2 c	3 c
For office use only:				
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 c	NO c
Most days I worry about lots of things.	YES c	NO c
Most days I cannot stop worrying	YES c	NO c
Most days my worry is hard to control.	YES c	NO c
I feel restless, keyed up or on edge.	YES c	NO c
I get tired easily.	YES c	NO c
I have trouble concentrating	YES c	NO c
I am easily annoyed or irritated.	YES c	NO c
My muscles are tense and tight.	YES c	NO c
I have trouble sleeping.	YES c	NO c
Did the things you noted above affect your daily life (at home, work or leisure) or cause you a lot of distress?	YES c	NO c
Were the things you noted above bad enough that you thought about getting help for them?	YES c	NO c

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

For office use only:

Total				

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

Moral Injury Events Scale (MIES)

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 = Strongly Disagree 2 = Moderately Disagree 3 = Slightly Disagree
4 = Slightly Agree 5 = Moderately Agree 6 = Strongly Agree

- | | |
|--|-----------------------------------|
| 1. I saw things that were morally wrong. | c 1 c 2 c 3 c 4 c 5 c 6 |
| 2. I am troubled by having witnessed others' immoral acts | c 1 c 2 c 3 c 4 c 5 c 6 |
| 3. I acted in ways that violated my own moral code or values | c 1 c 2 c 3 c 4 c 5 c 6 |
| 4. I am troubled by having acted in ways that violated my own morals or values | c 1 c 2 c 3 c 4 c 5 c 6 |
| 5. I violated my own morals by failing to do something that I felt I should have done | c 1 c 2 c 3 c 4 c 5 c 6 |
| 6. I am troubled because I violated my morals by failing to do something I felt I should have done | c 1 c 2 c 3 c 4 c 5 c 6 |
| 7. I feel betrayed by leaders who I once trusted | c 1 c 2 c 3 c 4 c 5 c 6 |
| 8. I feel betrayed by fellow service members who I once trusted | c 1 c 2 c 3 c 4 c 5 c 6 |
| 9. I feel betrayed by others outside the U.S. military who I once trusted | c 1 c 2 c 3 c 4 c 5 c 6 |

For Office Use Only:

Total					

Scoring:

9 or less — None; 10 to 22 — Some; 27 to 36 — moderate; 36 or above — severe

Anger Evaluation

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

For office use only:

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How did you find out about me?

Personal Referral

Who Referred you? _____

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

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? NO YES

Was my web site helpful in your decision? NO YES