Life Script Mental Health Counseling Services PLLC

"Helping You Reclaim Your Life"

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www.lifescriptcounseling.com

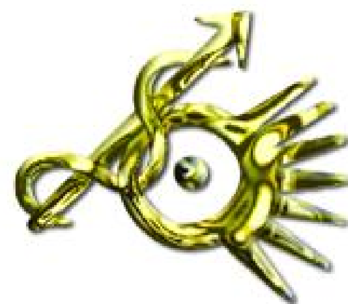
INSTRUCTIONS:

You may fill this form out online using Adobe Acrobat Reader's (it's free) fill and sign function.

When completed you may return it to me via Email: info@lifescriptcounseling.com

Alternatively, you may print it out, fill it in by hand and bring it with you to our first session, or FAX: 585-787-7478.

Thank You!



INTAKE FORM

PERSONAL DATA

Date: ______________________________

Name: ______________________________

Street: ______________________________

City: ______________________________

State: __________ Zip: __________________

Birth Place: ______________________________

Age: _______ Birth Date: ______________

Home Phone #: ______________________

Mobile: ______________________________

E-Mail: ______________________________

EMPLOYMENT DATA

Employer: ______________________________

Street: ______________________________

City: ______________________________

State: __________ Zip: __________________

Job Title: ______________________________

Years Employed: ______________________

Work Phone #: ______________________

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:______

☐ 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: ______

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

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 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?	☐	☐
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?	☐	☐
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	☐
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 ☐
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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

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

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

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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 ☐	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 ☐
	For office use only:		

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