Chuck Fallon, LPC Intake Form

The following information is needed to best help you. Please print your responses clearly.
Case records are strictly confidential.

SECTION I: IDENTIFYING INFORMATION

Today's Date ______/_____/_______

Contact First Name ___________________________________ Last Name _____________________________

Address ______________________________________City ________________ State ______ Zip__________

Phone: *Please check preferred contact phone number.*

☐Home _______________________ ☐Work ________________________ ☐Cell ____________________

E-mail Address ____

Date of Birth ______________ Age ______ Gender: F M Ethnicity ______________

☐Single ☐Engaged ☐Married ☐Divorced ☐Separated Years Married? ____ No. of Children ______

Family Members Currently Living In Home		
Full Name	Relationship	Age

Employer ____________________________________ Salary ____

Spouse, Child or Person in Counseling with Client *(if applicable)*

First Name ________________________________ Last Name ____

Date of Birth ______________ Age ______ Ethnicity ______________

Employer ____________________________________ Salary ____

Emergency Information

Name ____________________________________ Relationship ________________ Phone ______________

Church Home: _____________________________________ City ______________________________________

Attendance: ☐Weekly ☐2x/Month ☐Monthly ☐Other _______________________

How did you hear about Chuck Fallon, LPC? ____

Payment Method: ☐Cash ☐Check ☐Credit Card

SECTION II: DESCRIPTION OF PRESENTING PROBLEM

Why did you decide to seek counseling: ____

____

____

What you want to work on while in counseling: ____

____

____

How long has this been a significant problem for you? Please be specific (i.e., not "all my life"). ____________

____

____

How would you estimate the severity of the problem at this time? (Place "X" on the line below)

What symptoms are you experiencing as a result of this problem? Please check all that apply:

- ☐ overeating
- ☐ restless
- ☐ rapid heart rate
- ☐ compulsive behaviors
- ☐ taking drugs
- ☐ depressed mood
- ☐ sweating
- ☐ fears/phobias
- ☐ odd behavior/thoughts
- ☐ crying
- ☐ trembling or shaking
- ☐ anxiety
- ☐ weight gain
- ☐ difficulty concentrating
- ☐ shortness of breath
- ☐ vomiting
- ☐ recent weight loss
- ☐ low motivation
- ☐ muscle tension
- ☐ distrust
- ☐ appetite changes
- ☐ aggressive behavior
- ☐ outbursts of temper
- ☐ jumpy
- ☐ social withdrawal
- ☐ feeling of worthlessness
- ☐ nightmares
- ☐ dizzy or lightheaded
- ☐ emotional problems
- ☐ stomach problems
- ☐ easily distracted
- ☐ fatigue/loss of energy
- ☐ chest pain
- ☐ sleeping patterns
- ☐ obsessions
- ☐ problems with work
- ☐ housing problems
- ☐ relationship problems
- ☐ drinking alcohol
- ☐ financial problems
- ☐ pain
- ☐ self-mutilation behaviors
- ☐ suicidal thoughts
- ☐ other: ____________
- ☐ other: ____________

SECTION III: MEDICAL HISTORY

Name of Physician____ Date of last physical exam: ___________

Phone _________________________ Location of office ____

List any significant past or current health, medical, or psychiatric issues:

Dates	Problem	Treatment	Hospitalized? (Y/N)

Have you ever had treatment by, or are you currently seeing, a psychiatrist, psychologist, therapist, or counselor? Yes ___ No ___

Dates	Problem	Therapist	Helpful? (Y/N)

Have you ever been given a mental health diagnosis in the past from a mental health professional?

Yes____ No____ If yes, as you understand it, what is/was that diagnosis? ______________________________

____

____

Have you ever been admitted into a mental health care facility? Yes____ No____

Dates	Name and Location of Facility

Have you ever attempted suicide? Yes____ No____ If yes, please explain.

____

____

Have any family members ever attempted suicide? Yes____ No____ If yes, please explain.

____

____

SECTION IV: MEDICATIONS AND SUBSTANCES

If applicable, please list all medications you are now taking or have taken in the past three months, including birth control pills, vitamins, herbs and supplements.

Medication	How Long Taken?	Prescribing Physician	Helpful (Y/N)

Substance Intake *(if applicable)*

Please list amount of daily **or** weekly (D/W) consumption of the following:

Coffee _____/____ Soda _____/____ Tea _____/____ Cigarettes _____/____

Alcohol _____/____ Type: _______________ Illegal Substance _____/____ Type: _______________

Do you use any of these substances to (check all that apply):

☐Manage Stress ☐To Relax ☐To Change Mood ☐For Sleep

SECTION V: FAMILY OF ORIGIN INFORMATION

Family Members: Include Blended Family Members

Name	Age	Relationship	Deceased (Y/N)

Have any members of your family had problems with:

	Name	Relationship	Deceased (Y/N)
Drugs/Alcohol			
Depression			
Anxiety			
Mental Problems			
Physical Illness			

Who do you rely on for support: ______________________________ Relationship __________________

NOTE: There is room on the following page to tell us what else we should know to give you the best care.

SECTION VI: Additional Information from Client **or** Counselor Notes