

New psychotherapy clients: Please print out, fill out and bring in for your first appointment, thanks.

INTAKE INFORMATION for counseling and psychotherapy at *theZenter*

Today's date (Case ID) : _____

GENERAL INFORMATION (client or parent):

Name: _____ Address: _____
Town/City: _____ State _____ zip code: _____ Date of birth: _____
SS#: _____ Home phone: _____
Business phone: _____ Cell phone: _____ *If it is ok for us to call you and leave a message. Please circle the number we may use.*
Race: _____ Gender: Female Male Age: _____ Educational level: Elementary ___
GED ___ High School ___ College ___ Graduate school ___
Emergency contact person: _____ Relationship to you: _____
Address: _____ City: _____ State: _____ zip _____
Phone: _____
Primary Care Physician (PCP): _____ Address: _____
Phone nr: _____ Do we have your permission to disclose information to your PCP ? Yes No

How did you hear about this office/this practitioner? _____
May we acknowledge the referral? Yes no

EMPLOYMENT:

Employer or school: _____ Length of time with current employer _____ Job title _____
Division _____ Shift _____ Job Category: Mgmt ___ Profess ___ Tech ___
Admin ___ Skilled ___ Unskilled ___

FAMILY:

Marital/Legal status (please circle): Single, Married, divorced, Widowed.
If Married, is this your first marriage? Y, N. How long have you been married? _____
Spouse/Significant other: Name _____ Age _____
Occupation _____ Employer: _____
How would you describe this person? _____
Children (if applicable): Describe child:
Name: _____ age: _____ Gender _____
Mother: Living Y N If yes, age _____ number of times married _____
Describe mother: _____
Father: Living Y N If yes, age _____ number of times married _____
Describe father: _____

INITIAL EVALUATION (client or parent information)
Please fill out what you have answers to and skip the rest.

What are you experiencing that led you to make this appointment? _____

Has this been a problem before? Y N, please elaborate: _____

What do you wish to change in your life? _____

What do we need to know to best help you? _____

Is your problem impacting your job performance Y N

HISTORY (client information):

Have you ever been in counseling/psychotherapy/support group? Y N. When? _____

With whom? _____. When was this terminated? _____. Why was it terminated? _____

Were previous treatment interventions helpful? Y N. Elaborate please: _____

Have you ever been hospitalized for emotional difficulties? Y N. If yes, when? _____

Where? _____. Who was your treating physician? _____

Are you currently being seen by another behavioral health clinician? _____

If you have used, when was the approximate last date you used: Caffeine: _____

Tobacco: _____ Alcohol: _____ Marijuana: _____ Stimulants: _____

Narcotics: _____ Cocaine: _____ Other: _____

Has anyone in your family ever had an alcohol or other drug problem? _____

Has anyone ever expressed concern about your own alcohol or other drug usage? _____

Is there any history of physical or sexual abuse in your family? _____

Have any family members had psychological or emotional issues Y N

If Yes, who? _____ When? _____ For how long? _____

Please include information about any known prenatal and perinatal events (events in the lives of you and your parents before and during your birth): _____

Relevant psychological and social conditions affecting your medical and psychiatric status at present _____

GENERAL HEALTH:

Do you exercise? Y N How often and what kind? _____

When was your last physical? _____ Are you under the care of a physician?

Y N, If yes, who? _____ What are you being treated for?

_____ May we disclose information to this physician? Y N

If yes, Address of physician: _____ phone: _____

Medications taken regularly? Y N. If yes, name and dosage: _____

What for? _____

Date of initial prescription or refills: _____ Over-the-counter meds: _____

Do you have any chronic physical problems? _____
 List major injuries _____ surgeries _____
 illnesses _____ Allergies and adverse reactions, or sensitivities,
 to foods, drugs and other substances? _____,
 or no known allergies (NKA) _____. Do you have any infectious diseases? _____

HAVE YOU RECENTLY EXPERIENCED ANY OF THE FOLLOWING?

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> loss of interest | <input type="checkbox"/> loss of appetite | <input type="checkbox"/> racing heart | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> too much sleep | <input type="checkbox"/> inability to enjoy life | <input type="checkbox"/> increased appetite |
| <input type="checkbox"/> trembling | <input type="checkbox"/> insomnia | <input type="checkbox"/> fainting | <input type="checkbox"/> fatigue |
| <input type="checkbox"/> choking | <input type="checkbox"/> dry mouth | <input type="checkbox"/> feeling worthless | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> fear of dying | <input type="checkbox"/> nausea | <input type="checkbox"/> trouble thinking | <input type="checkbox"/> pressure in chest |
| <input type="checkbox"/> vomiting | <input type="checkbox"/> fear of travel | <input type="checkbox"/> arm/leg pain | <input type="checkbox"/> feeling keyed up |
| <input type="checkbox"/> hot flashes | <input type="checkbox"/> angry outbursts | <input type="checkbox"/> loss of weight | <input type="checkbox"/> fear of 'going crazy' |
| <input type="checkbox"/> fears | <input type="checkbox"/> nightmares | <input type="checkbox"/> easily startled | <input type="checkbox"/> poor concentration |
| <input type="checkbox"/> chills | <input type="checkbox"/> flashbacks | <input type="checkbox"/> feeling on edge | <input type="checkbox"/> numbness/tingling |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> painful periods | <input type="checkbox"/> smothering | <input type="checkbox"/> loss of energy |
| <input type="checkbox"/> sweating | <input type="checkbox"/> low self-esteem | <input type="checkbox"/> irritability | <input type="checkbox"/> lump in throat |
| <input type="checkbox"/> forgetfulness | <input type="checkbox"/> restlessness | <input type="checkbox"/> feeling hopeless | <input type="checkbox"/> sudden/intense anxiety |
| <input type="checkbox"/> racing thoughts | <input type="checkbox"/> gaining weight | <input type="checkbox"/> think too much | <input type="checkbox"/> feeling smothered |
| <input type="checkbox"/> feeling sad | <input type="checkbox"/> crying | <input type="checkbox"/> increased night dreams | <input type="checkbox"/> general anxiety |
| <input type="checkbox"/> thoughts of harming self or others | | <input type="checkbox"/> waking up frequently during sleep | |
| <input type="checkbox"/> difficulties falling asleep | | <input type="checkbox"/> my pain medication stopped working | |
| <input type="checkbox"/> feeling like I have to do the same thing repeatedly | | | |

RESOURCES:

To whom do you turn for strength? _____

Tell us about your support systems if you have such _____

Some people have religious practices that offer support, do you have such practices? _____

please elaborate: _____

What have you done in the past to assist you in times of crisis? _____

What are the health, wellness and leisure practices that you routinely participate in? _____

Where were you born? (state, county, country) _____

Where is your family from? _____. Original origin of family: (I.e. England, Denmark)

Father's side _____ Mother's side _____

LEGAL HISTORY:

Have you ever been convicted of a felony offence? _____ If yes, please elaborate _____

Thank you, please return this form to Inge Mula Myllerup-Brookhuis Cand.Psych. LPC, CEAP

FOR OFFICE USE:

DSM IV Multiaxial Diagnosis:

Axis I Dx Code _____

Axis II Dx Code _____

Axis III Current general medical condition potentially relevant to the understanding or management of the condition(s) noted in Axis I or II: Yes No

Axis IV Severity of current psychosocial stressors:

None mild moderate severe

Axis V GAF score: Highest pasts year at first session

Symptoms: (If applicable)

Self injurious behavior:	Mild	moderate	severe
Suicidal ideation:	mild	moderate	severe
Homicidal ideation:	mild	moderate	severe
Substance use problems:	mild	moderate	severe

Signature by clinician _____
Inge 'Mula' Myllerup-Brookhuis Cand.Psych. M.A. LPC CEAP

MENTAL STATUS EXAMINATION

INTELLIGENCE:

- limited
- slow
- average
- bright

ATTENTION TO TASK:

- distractible
- needs constant reinforcement
- persistent
- perseveration
- short attention span
- attentive

ASSOCIATIONS:

- appropriate
- restricted
- circumstantial
- tangential
- loose
- flight of ideas
- clang
- rhyming
- punning
- impoverished

PERCEPTIONS:

- illusions
- auditory hallucinations
- visual hallucinations
- tactile hallucinations
- olfactory hallucinations
- perceptual distortions
- reality based

MEMORY IMPAIRMENT

- recent
- remote
- selective
- none apparent

JUDGEMENT:

- objective
- subjective
- age appropriate

INSIGHT:

- aware of problem(s)
- little insight
- other

LOOK APPROXIMATELY:

- Stated Age
- Older
- Younger

AFFECT:

- Appropriate
- Depressed
- Flat
- Anxious
- Inappropriate
- Elated
- Blunted
- Labile

SLEEP IMPAIRMENT:

- difficulty falling asleep
- wakes during night
- wakes too early
- nightmares
- night terrors
- sleep walking
- enuresis
- encopresis
- other (explain)
- no impairment

SUBSTANCE ABUSE:

- tobacco
- caffeine
- alcohol
- marijuana
- inhalants
- PCP
- Rx medications
- OTC drugs
- amphetamines
- barbiturates
- cocaine
- other (explain)
- none identified

NEUROLOGICAL DIFFICULTY

- hop on one foot
- skip
- fingers - thumb
- alternate movement of hands
- associate movement
- right - left confusion
- eye tracking

- write own name
- over-active reflexes
- underactive reflexes
- toe walking
- alternating feet on stairs

VISION:

- appears normal
- other

HEARING:

- appears normal
- other

- Cooperative
- Guarded
- Hostile
- Suspicious
- Superficial
- Demanding
- Frightened
- Unresponsive

APPEARANCE:
 Neat/well groomed
 Disheveled
 Casual
 Bizarre

MOOD:
 Worried
 Sad
 Despondent
 Fearful
 Happy
 Withdrawn
 Normal

SPEECH:
 Average
 Mute
 Non-spontaneous
 Pressured
 Mumbled/Indistinct
 Loud
 Soft
 Halting

BEHAVIOR:
 Crying
 Seductive
 Tense
 Aggressive
 Threatening
 Relaxed
 Rigid
 Agitated
 Catatonic Stupor

ASSOCIATIONS:
 Logical
 Tangential
 Circumstantial
 Concrete
 Flight of Ideas
 Disorganized
 Blocked
 Racing
 Preservative
 Loose

THOUGHT CONTENT:
 Sparse
 Autistic
 Depersonalization
 Ideas of Unreality
 Obsession
 Phobias
 Delusional
 Hallucinations

ORIENTATION:
 Intact: Time Person
 Disoriented: Place Situation

MEMORY IMPAIRMENT:
 None
 Mild
 Moderate
 Severe

IMMEDIATE RECALL:
 Intact
 Mild Loss
 Moderate Loss
 Severe Loss

INSIGHT _____ INTELLIGENCE _____ JUDGEMENT _____

ADDITIONAL COMMENTS:

APPETITE IMPAIRMENT

eat too much
 recent weight loss
 picky eater
 food fads
 anorexia nervosa
 poor appetite
 pica
 binge eating
 no impairment

Name: _____
Signature of Observer _____ Title _____ Date _____

