Suzanne Oelke LMHC

INTAKE FORM

DATE: _____Birth Date_____

NAME:_____ GENDER:_____ AGE: _____

RACE/ETHNICITY (OPTIONAL): _____

LOCAL ADDRESS_____ CITY:_____ ZIP:_____

Can you receive confidential mail here (Y?N): _____
If no, where can you receive confidential mail: _____

May I contact you through e-mail for scheduling purposes (Y/N)? _____
Email Address: _____(Email is not a confidential form of communication)
May I contact you through text for scheduling purposes(Y/N)? _____

LOCAL PHONE: _____ May I contact you here(Y/N)? _____May I leave a message(Y/N)? _____
CELL PHONE: _____ May I contact you here (Y/N)? _____May I leave a message (Y/N) _____

How did you hear about me? _____

Who, if anyone, suggested you get counseling? _____

Briefly tell me about the concerns you have:

Please check any current or past issues that still affect you:

___Eating Disorders	___Financial Issues	___Academic Issues
___ Depression	___Pregnancy Issues	___Spiritual Concerns
___Pornography	___Stress/Anxiety	___Sexual Identity Issues

___Alcohol/Drug Use ___Suicidal Thoughts _____Other

___Sexual Assault/Rape If yes, when?_____

___Death of someone close? If yes, recently or in the past _____

___Addictions? Type? _____

___Family Issues (For example, divorce, domestic violence, alcoholism)

___Relationship concerns: ___family ___ friend ___ parent ___ significant other ___ roommate

___Other

Your History:

Current Medical Conditions: _____

List all current medications, including herbal, and how long you have been taking them:

_____

Have you been on any medications in the past form mental health issues? If yes, please list.

_____

Have you previously seen a therapist? ___ Who? _____When?_____

Where?_____

For what types of issues? _____

Have you ever been hospitalized for physical or mental health issues?_____

Briefly Describe:_____

_____

Have you ever had any suicide attempts?___ Briefly Describe: _____

_____

Does anyone in your family have a history of mental or physical health issues? _____

Who? What type?_____

If you currently experience any of the following symptoms, please rate using the key below:

0-Never 1-Sometimes 2-Often 3-Always

___ Difficulty Concentrating
___ Crying
___ Missing Classes
___ Feeling Helpless
___ Feeling uptight
___ Worrying
___ Feeling Hopeless
___ Feeling Afraid
___ Lying to Others
___ Feeling out of control
___ Feelings of self doubt
___ Nervous around others
___ Stealing
___ Memory loss or black out
___ Self Injury How?_____
___ Physical symptoms (head aches, digestive problems _____
_____
Have you seen a health care provider for these? _____
___ Other Please describe:_____

___Anger
___ Negative Thoughts About Body
___ Consumed With Changing Appearance
___ Distress when exercise routine is disrupted
___ Eating Binges
___ Restricting food or not eating
___Purging / throwing up
___ Drinking Heavily
___ Other drug use
___ Guilt feelings
___ Withdrawing socially
___ Suicidal thoughts
___ Sexual preoccupation
___ Difficulty sleeping

Please describe any current or past medical problems:

Emergency Contact:_____ Phone Number: _____

Relationship to you? _____

Family Doctor? _____ Phone Number:_____

Relationship status (circle one) Single Married Partnered Separated Divorced Widowed

Spouse / Partner's first name: _____ Age:____ Years in Relationship? _____

Children (gender, age) _____

Insurance Information:
Name of Insurance Company:_____Plan Name:_____

MemberID #_____GroupID#_____

Copay_____Deductible_____

Responsible Party_____