Lacamas Counseling & Psychiatry
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LACAMAS COUNSELING & PSYCHIATRY

INTAKE INFORMATION

CONTACT INFORMATION & DEMOGRAPHICS

Full name: _____ **Date:**_____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Email address: _____ **Phone:** _____

Check mark approved communication: □Voicemail □Text □Email

Emergency Contact Name & Phone: _____

DOB: _____ **Age**: _____ **Sex:** □**Male** □**Female** □_____

Gender Identity: _____ **Preferred Pronouns:** _____

Race/Ethnicity: _____

Occupation: _____

Spiritual/Religious Beliefs: _____

What concerns or problems bring you to counseling? Be as specific as you can

_____

_____

_____

What are your goals for counseling?

_____

_____

Describe any past or current suicidal thoughts or attempts:

_____

_____

Describe any addictions or addictive behaviors that affect you:

_____

_____

Describe any pertinent family history, abuse, or trauma:

_____

_____

_____

List any previous mental health or developmental diagnoses:

_____

_____

Please describe any family history of mental illness or diagnoses:

_____

_____

What are your spiritual and religious beliefs?

_____

_____

Have you received counseling before? If so, how was your experience?

_____

_____

Who are your medical providers?

Primary Care Physician Name _____
Phone Number _____
Clinic Name _____

Other Medical Provider _____
Phone Number _____
Clinic Name _____

Other Medical Provider _____
Phone Number _____
Clinic Name _____

List any pertinent medical conditions, health problems, and/or past hospitalizations

_____

_____

Specify all medications and supplements you are taking and for what reason

_____

_____

FAMILY

Who lives with you:

Name	**Age**	**Relationship**

Who else is significant and/or supportive in your life:

Name	**Age**	**Relationship**

What else would you like me to know:

_____

_____

_____

_____

Check any of the following symptoms that have impacted you in the last six months

Depressed Mood
Tiredness/Fatigue
Low energy
Tearfulness
Hopelessness
Apathy/Lack of care
Loss of interest/pleasure
Low self-worth
Low motivation
Isolation from others
Difficulty concentrating
Racing thoughts
Lack of confidence
Increased appetite
Decreased appetite
Irregular sleeping
Anxiety
Panic
Fear
Social anxiety
Panic attacks
Thoughts of harming another person
Suicidal thoughts
Self-harm
Guilt/Shame
Inconsistent mood changes
Excessive Energy
Impulsivity
Compulsive Behaviors
Obsessions
Hear/see things others do not
Paranoia/Suspicion
Reckless Behaviors
Exposure to traumatic event
Flashbacks (while awake)
Nightmares
Avoidance of trauma reminders
Easy startle reflex
Irritability/Anger
Frequent anger outbursts
Other symptoms _____

What stressors/changes have recently impacted you?

Burnout/Stress
Excessively busy
Relocation/Recent move
Career/Job
Retirement
Unemployment
Medical/health
Legal matters
Finances
Finding meaning & purpose
Identity
Religion/spirituality
Parenting difficulties
Divorce/Separation
Grief/Loss
Sexual abuse/rape
Emotional abuse/control
Physical abuse
Residual problems from childhood abuse
Alcohol/drugs
Post-partum transitions
Infertility/Miscarriages
Abortion
Social life
Extended family
Chaotic life
Something else _____

How are these symptoms and stressors affecting your every day life?

Personally _____
Family _____
Friendships _____
Social life _____
Work/School _____
Every day tasks _____