Lifeline Family Enrichment Counseling

12343 Hymeadow Drive, Suite 2F, Austin, Texas 78750-1839

NEW PATIENT INTAKE FORM

(Please reach each question carefully and provide detailed answers).

Name: _____ DOB: _____

1. **Have you ever been hospitalized for a psychiatric issue? □ Yes □ No If yes, list when, where, and reason for hospitalization**

2. **What brings you to counseling at this time? If there is something specific, such as a particular event? Be as detailed as you can.**

3. **Do you use recreational drugs? □ Yes □ No If yes, list drug and how often you use.**

4. **Is there a history of mental illness in your family? □ Yes □ No If yes, list family member and diagnosis.**

5. **What are your goals for counseling? How will you know when you have reached these goals?**

6. **Are you currently involved in a relationship? □ Yes □ No If yes, please describe the nature of the relationship and the months or years you have been together.**

7. **Do you have suicidal thoughts? □ Yes □ No If yes, how often, and when was the last time?**

8. **Describe your current living situation. Do you live alone or with someone (spouse, friend family, etc.)? List everyone in your household.**

9. **Have you seen a mental health professional before? (ie Counseling) □ Yes □ No If yes, with whom, and when.**

10. What is your level of education? List your highest grade/degree and type of degree.

11. What is your current occupation? Describe your responsibilities and how long have performed these duties.

12. Identify and list *all* medications and supplements you are presently taking. Name of the medication, how much you take, how often and the purpose for taking medication.

13. Have you ever attempted suicide? □ Yes □ No If yes, how many times, when and what method dis you use?

14. If taking prescription medication, who is your prescribing MD? Please include type of MD, name and phone number.

15. **Who is your primary care physician? Please include type of MD, name and phone number**.

16. Do you have thoughts or urges to harm others? □ Yes □ No If yes, how often?

17. Do you drink alcohol? □ Yes □ No If yes, what, how often and how much? At what aged did you start?

18. Your age of emancipation from home and reason,

19. Describe any special circumstances that occurred in your childhood. Please be specific.

20. Have you ever been the victim of emotional abuse? □ Yes □ No If yes, when and by whom?

21. **Have you ever been the victim of physical abuse? □ Yes □ No If yes, when and by whom?**

22. **Have you ever been the victim of sexual abuse? □ Yes □ No If yes, when and by whom?**

23. Have you ever experienced a traumatic life event? (Abuse, domestic violence, fire, hurricane, tornado, automobile accident, homelessness, etc) If yes, explain.

24. Describe any past or current issues with your intimate relationships.

25. **Describe any past or current issues in family relationships**.

26. Do you currently participate in any recreational activities or hobbies? If yes, list.

27. Do you currently participate in any spiritual/cultural activities? If yes, explain.

28. Would you like to incorporate your spiritual belief with your counseling? □ **Yes** □ **No If yes, how?**

29. In the past two years have you experienced any deaths or losses (moving, changed jobs, fired, breakups, etc.)? If yes, explain.

Symptom Checklist

(Please place an (X) by any symptom you are currently experiencing or have experienced within the last 30-days).

□Depressed Mood

□Change in appetite

□Change in sleeping habits

□Fatigue/lack of energy

□Problem concentrating

□Poor grooming/hygiene

□Mood swings

□Agitation

□Irritable

□Anxiety

□Fears

□Paranoid Ideation

□Delusions

□Hallucinations

□Aggression

□Conduct Problems

□Oppositional Behavior

□Worthlessness

□Guilt

□Hopelessness

□Panic Attacks

□Obsessive Thoughts