PENNY MANNING LCPC

Intake Form

Please note: Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

CLIENT INFORMATION

Name: _____ SSN: _____
Email address: _____ May we email you? _____
Phone: _____ May we leave a message? _____
Birth Date: _____ Age: _____
Gender: _____

Marital Status (please circle):
Never Married Domestic Partnership Married Separated Divorced Widowed

Please list any children/age: _____

Home address: _____
Street and Number City, State, Zip

Occupation: _____ Employer: _____

Referred by (if any): _____

INSURANCE INFORMATION

Person responsible for this account: _____ Relationship to patient: _____
Subscriber Name: _____ Subscriber Policy: _____
Insurance Provider: _____ Group #: _____
Customer Service # (found of back of card): _____ DOB of insured: _____

ADDITIONAL INFORMATION

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

☐ No
☐ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?

☐ No
☐ Yes, please list: _____

Have you ever been prescribed psychiatric medication?

☐ No
☐ Yes, please list and provide dates: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing: _____

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing: _____

_____

3. How many times per week do you generally exercise? _____
What types of exercise do you participate in? _____

4. Please list any difficulties you experience with your appetite or eating patterns: _____

_____

5. Are you currently experiencing overwhelming sadness, grief, or depression? _____
If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias? _____
If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? _____
If yes, please describe: _____

8. Do you drink alcohol more than once a week?

9. How often do you engage in recreational drug use? (please circle)
Daily Weekly Monthly

10. Are you currently in a romantic relationship?

- ☐ No
- ☐ Yes, for how long?: _____
- ☐ Infrequently
- ☐ Never

On a scale of 1-10, how would you rate your relationship? _____

FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Please circle. If yes, please list family member(s)

Alcohol/Substance Abuse: yes/no
Anxiety: yes/no
Depression: yes/no
Domestic Violence: yes/no
Eating Disorders: yes/no
Obesity: yes/no
Obsessive Compulsive Behavior: yes/no
Schizophrenia: yes/no
Suicide Attempts: yes/no

RISK ASSESSMENT

Please circle any risk factors present. If yes, specify current risk factors

Potential for violence: yes/no
Hostile or abusive behavior: yes/no
Major Depression: yes/no
Suicidal ideation, intent, or plan: yes/no

PAST RISK FACTORS

Suicide Attempts: yes/no
Violent Behavior: yes/no
Inpatient Hospitalization: yes/no
Hostile or abusive behavior: yes/no
Major Depression: yes/no
Suicidal ideation, intent, or plan: yes/no

ADDITIONAL INFORMATION:

1. Are you currently employed? _____
If yes, what is your current employment situation? _____

Do you enjoy your work? Is there anything stressful about your current work? _____

2. Do you consider yourself to be spiritual or religious? _____
If yes, describe your faith or belief: _____

3. What do you consider to be some of your strengths? _____

4. What do you consider to be some of your weaknesses? _____

5. What would you like to accomplish out of your time in therapy? _____

6. What significant life changes or stressful events have you experienced recently? _____