Life Strategy Center
Helping Change Lives for the Better

Intake Summary

This form gathers information to help your therapist understand your situation and provide you the best possible services. If you have questions, please ask. You may skip questions that cause you to feel uncomfortable.

The information you share during your treatment at Life Strategy Center will be kept strictly confidential except when:

- You sign a specific release to disclose information to a person, party or agency.
- We learn that you have harmed a child, elder, or disable person. Such information has to be reported to Family Services or Law Enforcement.
- We have reasonable knowledge or suspicion that you pose a risk of harm to yourself or others—we will take actions to protect you and others in this case.
- Required in civil or criminal legal proceedings.

Date _____
Name _____ Phone # _____
Physical Residence _____
Mailing Address _____
City _____ State _____ Zip _____
Age _____ Date of Birth _____ Gender _____ Marital Status _____

For use only in the event of an emergency, please provide the following:
Parent/Guardian/Partner's Name(s), Phone Number and Mailing Address:
_____

Have you served in the Military?
If yes, please state which branch and how long? _____

Referred by: _____ May we contact them?

Are you currently receiving services from:

- _Dept. Workforce Services
- _Mental Health Center
- _Dept. Family Services
- _Division of Vocational Rehabilitation
- _Veterans Affairs
- _Other_____

_____ Please initial in this space if you desire collaboration between Life Strategy Center and any of the agencies listed above to help you meet your goals successfully.

Are you currently on probation/parole?
If yes, please explain: _____
Court Order? If so, which court? _____

Do you have insurance coverage? If yes, we will need a copy of your insurance card.

Specific Symptoms or Problems

Goals for counseling:

_____

Describe what your most pressing problems that may be addressed in counseling:

_____

_____

Depression – (If yes, complete the depression screen below)
Anxiety/Panic – (If yes, complete the anxiety screen below)
Body Weight/Shape Concerns
_____ Drinking/Drugs
Suicidal Thoughts
_____ Anger Outbursts
Concerns about physical safety of self or others
Relationship Problems
_____ Other Problems _____

Medical and Counseling/Psychological/Psychiatric History

What medicines are you currently taking (include vitamins and OTC medications) and who prescribed

_____

_____

_____

Who is your primary care medical provider? _____
When was your last medical checkup / Exam? _____
Results? _____
_____ Have you received counseling, psychological, psychiatric services before?
If yes, please explain: _____
_____ Has anyone in your family had problems with depression, anxiety, alcohol/drugs or any other emotional problems?
Have you received Alcohol/Substance abuse treatment before?
_____ Have you ever considered, or attempted suicide?
_____ Have you ever been sexually or physically abused?
Have there been any major illnesses or accidents?
_____ Have you ever had a head injury or concussion?
_____ Do you smoke/use tobacco/vape
_____ Caffeine use including coffee, sodas, teas, energy drinks?

Background Information

_____ Is there any current legal involvement?
If yes, please explain: _____
_____ Currently employed? If so, Where? _____
Education:

Alcohol, Substance Use/Abuse History

_____ Alcohol use?
How frequently do you drink? _____
Approximately how many drinks per week? _____
_____ Drug Use?
If you use drugs, what do you use and how often? _____
_____ Has your use/abuse of alcohol or drugs ever caused you difficulties at work, home, school, or legal problems?
If yes, please explain: _____

If you suffer from anxiety, please complete this Anxiety Screen

_____ Do you have times when you suddenly feel an unexpected rush of intense fear, or suddenly develop symptoms?
If yes, please explain: _____
_____ Are you fearful of going out of the house alone, being in crowds, places where you feel confined, or where it would be difficult to get help if you needed it?
If yes, please explain: _____
_____ In social situations when you meet new people, or introduce yourself, do you feel nervous or anxious?
If yes, please explain: _____
_____ Do you worry that you may embarrass yourself or that others will think badly of you?
_____ Over the past 6 months, have you been continually worried about a number of events or activities in your life?
If yes, please explain: _____
What types of things do you worry about? _____
_____ Restlessness, or feeling wound up or on edge?
Difficulty concentrating or your mind frequently going blank?
_____ Irritability?
_____ Muscle Tension?
_____ Sleep difficulties?
If yes, please explain: _____
_____ Are you currently bothered by images, thoughts, or impulses that are upsetting, that don't make sense, and keep coming back even when you try not to have them?
If yes, please explain: _____
_____ Do you have specific fears; such as heights, flying, driving, blood, needles, insects, animals, enclosed places, or normal human interactions (talking, touching, sex)
If yes, please explain: _____
_____ Have you experienced or witnessed a traumatic or life threatening event such as assault, rape, being abandoned, or seeing someone badly injured or killed, combat, accidents, or natural or man-made disasters?
If yes, please explain: _____
_____ Are you bothered by recollections of the events, or try hard to not to remember them?
If yes, please explain: _____

If you suffer from symptoms of depression, please complete this Depression Screen

_____ Have you been persistently sad for most days of the last two weeks?
Have you lost interest or enjoyment in previously enjoyable activities?
_____ Have you had weight loss without dieting?
If yes, please explain: _____
_____ Have you had weight gain? In what time frame? _____
_____ Do you have insomnia (inability to sleep)?
If yes, please explain: _____

_____ Do you have hypersomnia (excessive sleep)?
If yes, please explain: _____
_____ Do you have fatigue or loss of energy nearly every day?
If yes, please explain: _____
_____ Do you have feelings of worthlessness?
_____ Do you think slow?
Have difficulty concentrating?
_____ Are you indecisive?
_____ Any thoughts of death?
_____ Have you had suicidal thoughts?
_____ What about suicidal plans?
If yes, please explain: _____
_____ If you have a plan, can you make it happen?
If yes, please explain: _____
_____ Past attempts?
If yes, please explain: _____
Why would you attempt suicide now? _____
_____ Do you believe you can control your actions?
_____ Do you fear losing control?
What is the worst thing you could do, and what is the worst thing that could happen?

_____
_____ Have any of these symptoms affected your daily life, job, or relationships?
If yes, please explain: _____
When did these problems start? _____
_____ Have you had them before?

Please note any additional concerns:

_____
_____
_____
_____
_____
_____