Elise Greene, LCSW
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Client Intake Form

Name_____**Nickname**_____

Gender____**Date of Birth**_____ **Marital Status**_____**Employment Status**_____

Home Address_____

City, State, Zip_____

Home Phone_____**Work Phone**_____

Cell Phone_____**Email**_____

Preferred contact number: (work/home/cell)_____**Is it okay to leave a voice message?**_____

Emergency Contact (Name/Relationship/Phone)_____

Are you interested in animal assisted therapy? Yes____ **No** _____ **Not sure** _____

INSURANCE INFORMATION (if applicable)

Insurance Company_____

Insured person's name_____

Insured's Street address_____

Insured's City, State, Zip_____

Insured's Phone Number_____

Insured's Date of Birth_____**Insured's Gender**_____

Insured's Employer_____

ID Number (found on insurance card)_____

Group Number (on insurance card)_____

Insurance Phone Number (on back of card normally)_____

RELEASE OF INFORMATION: I authorize Elise Greene, LCSW, to obtain/release/exchange information with my Primary Care Physician (PCP) or as requested by my insurance company for the purpose of service coordination and continuity of care.

Primary Care Physician/other practitioner name_____

Address_____

Phone_____ Fax_____

___Check here if you choose not to release information

_____
Signature of patient or responsible party

BEHAVIORAL HEALTH HISTORY

What led you to decide to seek counseling at this time?_____

_____

Check the box beside each concern experienced recently

	Anxiety		Depression		Sleep problems		Thoughts of suicide
	Panic		Unusual thoughts		Anger outbursts		Changes in weight
	Crying spells		Memory problems		Sexual problems		Relationship difficulties
	Treated unfairly		Frequent pain		Low energy		Concentration problems
	Restlessness		Nausea		Eating disorder		Legal difficulties
	Drug use		Drinking problem		Boredom		Hopelessness
	Stress		Shyness		Work problems		Confusion
	Guilt feelings		Suspicion		Loneliness		Thoughts of hurting others
	Compulsions		Worry		Money problems		Difficulty with decisions
	Specific fears		Mourning		Physical illness		Poor motivation
	Feeling abandoned		Meaninglessness		Perfectionism		Unusually sensitive
	Irritability		Social withdrawal		Feeling misunderstood		Troublesome thoughts
	Religious concerns		Disappointment		Impulsive		Hearing strange voices
	Feeling inferior		Irrational thoughts		Mood swings		No problems or concerns

Other additional concerns or symptoms:_____

_____

Have you experienced any stress or life changes lately? Please describe

_____

_____

Have you seen a therapist or psychiatrist in the past? Yes____ No_____

Have you been hospitalized for psychiatric reasons? Yes____ No_____

If yes for either of these two questions, please fill out the following:

Year	Problem	Therapist or clinician	How long

Have you ever been prescribed medications for your emotions in the past?

Yes____ No____

Please list _____

Have you ever felt the need to cut down on your drinking? Yes_____ No_____

Have you ever felt annoyed by criticism of your drinking? Yes_____ No_____

Have you ever felt guilty about your drinking? Yes_____ No_____

Have you ever taken a morning "eye opener"? Yes_____ No_____

How much beer, wine or liquor do you consume each week on average? _____

_____

How much tobacco do you smoke or chew each week?_____

Which drugs (not medications prescribed for you) have you used in the past 10 years?

_____

Is there any family history of drug or alcohol use? Yes_____ No_____

(Please explain) _____

_____

Is there any history of violence, verbal or sexual abuse in your family? Yes_____ No_____

Have you been exposed to trauma in the past? Yes_____ No_____

(If the answer was yes to any of the questions above, please elaborate with your counselor)

Check the box beside issues experienced in childhood

	Happy Childhood		Neglected		Moved frequently
	Physically abused		Few friends		Sexually abused
	Weight problems		Popular		Parents divorced
	Family fights		Poor grades		Conflict with teachers
	Drug or alcohol use		Good grades		Sexually active
	Depressed		Anxious		Not allowed to grow up
	Attention problems		Anger problems		Other

Your family growing up:

Relationship (include siblings and other significant relationships)	**First name**	**Mental Health History**
Mother		
Father		

LIFE/WORK/PLAY

Are you currently… Working____ In school ____ both ____ neither____

Highest level of education so far _____

What is your current or most recent job title? _____

In what field do you work? _____

How many hours per week are you working? _____

Briefly describe what you like and dislike about your employment or school

_____

_____

_____

Do you have any legal issues pending? Yes____ No____

How do you spend your personal time (hobbies, sports, clubs, groups, family activities, etc.)

_____

_____

_____

How many contacts do you have each month with friends outside of work or school? _____

Who can you talk with about your personal feelings or private matters? _____

Where are you currently living? House ____ Apartment ____ With relatives___

Dorm ____ Health care facility ____ Retirement community ____ Other____

Who lives with you now?

Relationship	First name

How well do you get along with your parents/spouse/partner and/or children?

_____

_____

_____

Are there any pets in your home? Yes_____ No_____

How does each family member treat the pet? _____

_____

_____

Do you worry about something bad happening to the pet? Yes_____ No____

MEDICAL CONDITIONS

Please check below if you have had any of the following medical conditions

	Arthritis		Stomach ulcers		Hyperthyroidism
	Hypothyroidism		Kidney problems		Colitis/Crohn's
	Chronic pain		Lupus		Tuberculosis
	Diabetes		Head injury/concussion		Seizures
	Heart attack		Angina		High blood pressure
	Urinary retentions		Migraines		Chronic headaches
	PMS		Asthma		Other respiratory problems
	Cancer		Hysterectomy		

Pregnancy: _____ times Miscarriage: _____times

Surgery:_____

Other:_____

Please list all current medications (use back of form if necessary):

Medication	Strength	Frequency	Date started	Prescribed by

Do you have any allergies to medication? Yes_____ No_____

(Describe)_____

How many hours do you sleep in an average night? _____

Do you exercise? How? How often?_____

Who is your primary physician (if not listed on page 1)_____

Primary physician phone number_____

When was your last physical? _____

Are you concerned about your physical health? _____

STRENGTHS AND RESOURCES

List your personal strengths, resources and important accomplishments

_____

_____

_____

List any additional information that it might be important for your counselor to know

_____

_____

_____

I certify that all information above is true and accurate.

_____ _____

Signature of client Date

_____ _____

Signature of parent/guardian if minor Date