LISA FRASER COUNSELING

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Psychotherapy Intake Form

Please answer the questions below and bring this form to your first session.
Any information you provide here is protected as confidential information.

Name: ____
Last First Middle Initial

If you are under 18 years old, please provide the name of your parent/guardian:

____
Last First Middle Initial

Birthdate: ______ / ______ / ______ Age: ________
Month Day Year

Gender: ____________________________

Marital Status: ☐ Never Married ☐ Domestic Partnership ☐ Married
☐ Divorced ☐ Widowed ☐ Separated

Please list any children, their ages, and whether they live with you:

____
____
____
____

Address:

____
Street and number

____
City State Zip

May I send mail to this address? ☐Yes ☐No

Preferred Phone #: ______________ This is a ☐Cell ☐Home ☐Work ☐Other: ______________
Email: ________________________
Preferred Communication: ☐Cell ☐HmPh ☐WkPh ☐Email
It is okay to leave a message on my: ☐Home ☐Cell ☐Work phone ☐Other __________
May I use email to confirm appointments? ☐Yes ☐No
May I use text to confirm appointments? ☐Yes ☐No

What prompted you to seek therapy?

____

____

____

Who is impacted by the issue?

____

____

Is there anything else you think would be helpful for me to know about you or your situation?

____

____

____

How did you find me? ☐ lisafrasercounseling.com ☐ Facebook
☐ Psychology Today ☐ Referred by: ______________________
☐ Other: ____

Have you had any prior counseling or psychiatric treatment? ☐ No ☐ Yes

If yes:

When? ______________________ Where? ____

Reason for and length of counseling: ____

Check one: Therapy was ☐ helpful / ☐ not helpful. Please explain:

____

____

____

Are you currently taking any prescription medication? ☐ Yes ☐ No
If yes, please list it/them below:

____

____

Aside from anything listed above, have you previously been prescribed psychiatric medication?

☐ Yes ☐ No If yes, please list it/them here and provide approximate date(s):

____

____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (Check one.)

☐ 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? (Check one.)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific sleep problems you are currently experiencing:

____

____

PLEASE CHECK BEHAVIORS AND SYMPTOMS YOU CURRENTLY EXPERIENCE

_______ Aggression
_______ Alcohol use
_______ Anger
_______ Anxiety
_______ Chronic pain
_______ Compulsive behavior
_______ Concentration problems
_______ Cyber addiction
_______ Depression
_______ Disorientation
_______ Distractibility
_______ Dizziness
_______ Drug dependence
_______ Eating disorder
_______ Fatigue
_______ Flashbacks
_______ Grief
_______ Hallucinations
_______ Heart palpitations
_______ High blood pressure
_______ Hopelessness
_______ Hyperactivity
_______ Impulsivity
_______ Irritability
_______ Loneliness
_______ Memory impairment
_______ Mood swings
_______ Obsessive thoughts
_______ Panic attacks
_______ Phobias/fears
_______ Poor judgment
_______ Self-esteem problems
_______ Sexual difficulties
_______ Sleep problems
_______ Social withdrawal
_______ Suicidal thoughts
_______ Thoughts disorganized
_______ Trembling
_______ Unresolved trauma
_______ Worrying
_______ Other: _____________

8. Do you drink alcohol more than once a week? ☐ Yes ☐ No

If yes, please estimate frequency: _______________________________________

9. How often do you engage recreational drug use?

☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

10. Have you received help for drug or alcohol dependency? ☐ Yes ☐ No

If yes, when? ______________________ Where? __________________________________

Check one: Treatment was ☐ helpful / ☐ not helpful. Please explain:

____

____

____

11. Are you currently in a romantic relationship? ☐ Yes ☐ No

If yes, for how long? ___________________

On a scale of 1-10, with 10 being the best, where would you rate your relationship? __________

FAMILY MENTAL HEALTH HISTORY

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

Issue	Yes	No	Family Member
Alcohol/Substance Abuse			
Anxiety			
Depression			
Domestic Violence			
Eating Disorders			
Obesity			
Obsessive Compulsive Behavior			
Schizophrenia			
Suicide Attempts			

ADDITIONAL INFORMATION:

1. Are you currently employed? ☐ No ☐ Yes

If yes, what type of work do you do?

____

____

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

____

____

2. Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes
   If yes, please describe your faith or belief:

   ____

   ____

5. What would you like to accomplish in therapy?

   ____

   ____

   ____

   ____

   ____

Thank you for taking the time to provide this information. Please feel free to contact me if you have questions before we meet.