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**INTAKE**

Please, print this form out and fill out as completely as possible and bring with you to your first session. It will help me in our work together. Do not email it to me. If you do not fill out the form we will need to do it together at the start of your first session. If there are questions that you do not want to answer, merely write "Do not care to answer." Information is confidential as outlined in the Office Policy form and HIPAA Notice of Privacy Practices.

**(Couples use same form – put your initials beside your information)**

Date \_\_\_\_\_

Name \_\_\_\_\_ Male / Female, Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

(For couples counseling) Name \_\_\_\_\_ Male / Female Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Partner's address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone: \_\_\_\_\_ / \_\_\_\_\_ Work phone \_\_\_\_\_

May I contact you at the above numbers? Y / N If not, how may I contact you? \_\_\_\_\_

Email address \_\_\_\_\_ May I contact you via email? \_\_\_\_\_

Emergency contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship to you \_\_\_\_\_

Employer and Job Title \_\_\_\_\_ / \_\_\_\_\_

(partner) Employer and Job Title \_\_\_\_\_ / \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Psychiatrist \_\_\_\_\_ Phone \_\_\_\_\_

Marital status Circle one: (Single/Married/Separated/Divorced/Widowed/Living with Significant Other/In relationship - not living together)

Culture/Race/Ethnicity \_\_\_\_\_ / \_\_\_\_\_

Legal Issues (past or current: divorce, bankruptcy, lawsuits filed by or against you, civil/criminal concerns, DUI, CPS involvement, bankruptcy, etc.):

Referral Source - how did you learn of me? (Friend, Doctor, Dex Yellow Pages, Online, Wingspan, other \_\_\_\_\_)

If you learned about me from my website, what led you to my website? (Google, Psychology Today, Therapy Tribe, etc.)

**TOPICS YOU WOULD MOST LIKE TO ADDRESS IN COUNSELING: Check up to 3 and rate them on a scale of 1-3 with "1" being your top concern**

- |   |  |
|---|--|
| ___ Relationship issues (be specific)     | ___ Trauma (rape, sexual abuse, violence, accident, etc.)                  |
| ___ Sexual issues                         | ___ Life transition (loss of job, empty nest, taking care of parents, etc) |
| ___ Women's issues                        | ___ Grief / Loss (death, loss of friend/lover/partner, career, house, etc) |
| ___ Depression                            | ___ Chronic pain   |
| ___ Anxiety (name your worries/fears)     | ___ Eating disorder/Compulsive overeating                                  |
| ___ Career/Work issues                    | ___ Body Image concerns  |
| ___ Spiritual/Religious/Cultural concerns | ___ Self-esteem problems   |
| ___ LGBTQ issues                          | ___ Sleep issues   |

**Use this space to provide additional information or to list a concern that is not included above:**

**PRIMARY CONCERN**

What issue or concern brings you to counseling? (Be specific: When did it start, how does it affect you and how severe is it?)

**COUNSELING GOAL**

What are your goals for therapy and what would you like to change in your life?

**MENTAL / EMOTIONAL HEALTH**

History of mental/emotional health concerns:

Previous counseling (Who, when, how long, reason for counseling, and if it was successful?)

Current prescribed psychotropic medications: List drug, dosage, prescribing doctor and what you are taking it for

**SUICIDALITY**

Are you currently having thoughts about death or suicide? \_\_\_\_\_ If yes, please immediately contact me and if you cannot reach me at **401-0935**, then call **911** or go to the nearest **emergency room**. You can also call the **24-hour Crisis Line in Tucson at 520-622-6000**.

Have you ever attempted suicide in the past? (If so, please describe how often, when, and what happened)

**MEDICAL**

List any current medical conditions

MEDICATIONS: List prescription medications you currently use (Include dosage and how often you take it and what you take it for)

List all over the counter drugs, herbs, and supplements you are currently taking and why you are taking them

Sleep concerns

Appetite - Are eating more or less than usual?

Eating Concerns – Describe: Anorexia, Bingeing, Purging, Compulsive Overeating, Binge Eating

Previous Treatment for Eating Disorders (Describe the disorder, in-patient, out-patient, when & where was the treatment, how long, was it successful?)

Concerns about your weight or body image

**Women:** Are you pregnant, still having your periods, peri-menopausal, menopausal, or post-menopausal

Problems with your cycle, (pain, irregular periods, excessive bleeding, PMS, hot flashes, vaginal dryness etc. and have you talked to a medical doctor about this?

**Men:** Do you have concerns about erectile dysfunction, low testosterone, prostate concerns and have you discussed this with your doctor?

### **SUBSTANCE USE**

Past and/or Current Substance Use/Abuse/Dependence and treatment

List any concerns you have about your use of drugs or alcohol?

Has anyone told you recently they are concerned with your use of drugs or alcohol?

How often do you drink alcohol or use recreational drugs?

How much do you use each time?

Describe any negative consequences as a result of your alcohol use (hangovers, blackouts, missing work, dropping grades, fights, arrests)

Do you want to reduce or stop your use of alcohol or recreational drugs?

Do you feel out of control with; gambling, pornography, spending, work, exercise, sex, eating, dieting, cleaning, etc.? (if so, please describe)

### **RELATIONSHIPS / FAMILY**

Describe present marriage or significant relationship (Years together, quality of relationship and any areas of concern):

List past relationships or marriages and important issues in those relationships:

Children/Step/Grandchildren (List names/ages & quality of relationship with each)

Parents/Step-parents (Name/age or year of death/cause of death, personality/how they treat(ed) you, quality of relationship:

**SIGNIFICANT EVENTS GROWING UP**

Describe any significant events, achievements, or memories from your childhood or adolescence. (May include awards or honors, traumas, accidents, abuse, developmental delays, disabilities)

**SOCIO-ECONOMIC**

Highest Level of Education

Are You Currently a Student (school, major, expected date of graduation)

Occupation/Job Title

Career/Education Goals

Please describe your living environment (house, apartment, farm, crowded, alone etc.

Gender Orientation: Lesbian/Gay/Bi-Sexual/Transgendered/Questioning or Heterosexual,

What are your strengths?

What do you like most about yourself?

What gives you the most joy or pleasure in your life?

What are your main worries and fears?

What are your most important hopes or dreams?

What are effective coping strategies that you've learned?

Do you identify with a faith, spiritual practice and/or culture that guides your day-to-day life?

How important is religion and/or spirituality to you rate on a scale of 0-5 (Zero being not important at all):

Is that something you want to talk about in counseling?