Laurie L. Rosen, *LCSW*
Licensed Clinical Social Worker

How were you referred? _____

Individual Intake Information (email for scheduling & administrative purposes only)

Name_____ DOB_____ EMAIL_____

Address City & Zip_____ Identifying Gender_____

Preferred Phone for contact & messages) CELL WORK HOME _____

Occupation, Employer & Address_____

ER Contact Name & Number (other than partner/spouse)_____

Circle One: Single - Engaged - Married - Divorced - Separated - Widowed

Duration of Current Relationship_____ Duration of Previous Marriages _____

Name of current partner/spouse_____ DOB_____

Occupation/Employer_____

Children from current or previous marriages/relationships School/Grade/Where residing

Name_____DOB_____ _____

Name_____DOB_____ _____

Name_____DOB_____ _____

Name_____DOB_____ _____

Others Residing in Home _____How long at current residence?_____

Family & Medical History (**Check all that apply indicating "S" for Self & "F" for Family**)

_____Depression _____Chronic Illness _____Neurological Problems _____Alcohol/Subst Abuse

_____Bipolar Disorder _____Physical Disability _____Learning Disability _____ADHD/ADD

_____GI/Digestion _____Mental Illness _____Personality Disorders _____Anxiety (OCD, panic)

_____Abuse- indicate: physical – sexual – emotional _____ Physical Illness (ex: cancer) _____Other

Current Medications & Who Prescribes?_____

Do you drink alcohol___ smoke_____ use drugs___ If yes, which & how often_____

Cutting Behavior_____Thoughts of Suicide_____ Suicide Attempts_____When_____

History of Medical/Mental Health Trauma_____

Previous Hospitalizations Where, When & Why_____

Name(s) of Previous Counselor(s)_____

Previous Counseling Issues_____

Are you adopted____ If so, at what age _____ Contact w/biological mother_____ biological father_____

Are parents divorced _____ How old were you _____With whom did you reside_____

Mother's name, age, residence _____

Father's name, age, residence_____

Siblings names, ages, residences_____

_____

Other significant family members in your life?_____

Significant family history/trauma: Relocation, Death, Divorce, Deployment, Conflictual Relationships

_____

Highest Level of Education_____ Financial or Legal Problems_____

Religious affiliation as a child _____ Religious affiliation as adult_____

Current Symptoms and Behaviors of Concern **(Please check all that apply)**

___ Anger

___ Addiction_____

___ Alcohol or Drug Use

___ Being Good to Yourself

___ Binge Drinking

___ Body Image

___ Career/ Work

___ Compulsions

___ Concentration Problems

___ Crying Excessively

___ Dating Concerns

___ Difficulty Managing My Emotions

___ Disorganization

___ Eating Too Little

___ Exercising Too Much/ Too Little

___ Finances

___ Flashbacks

___ Hypervigilance

___ Impulsivity

___ Irritability

___ Lack of Ambition/Motivation

___Marital relationship

___ Nightmares

___ Obsessions

___ Overeating

___ Parent-Child Conflict

___ Passivity

___ Peer Relationships

___ Procrastination

___ Recklessness

___Self-harming Behavior

___ Sexually Acting Out

___ Sexual Problems/Dysfunction

___ Sleeping Problems

___ Socializing

___ Social Withdrawal

___ Spiritual/Religious

___ Suicidality/Attempts

___ Thoughts of harming others

___Other_____

<u>Physical Symptoms</u> ("C" currently experiencing, and/or "P" in the past (all that apply)

___ Bowel Disturbance	___ Excessive Fatigue/Tired	___ Numbness/Tingling
___ Blackouts	___ Excessive Sweating	___ Poor appetite
___ Chronic Pain	___ Fainting	___ Tension
___ Constant Hunger	___ Headaches	___ Rapid Heartrate
___ Dizziness	___ Hearing Voices	___ Vision problems
___ Easily Startled	___ Incoherent Thoughts	

Circle a number to rate the severity of the presenting problem on a scale of 1-10 based on how much it impacts your daily functioning.

1 2 3 4 5 6 7 8 9 10

Little to no impact — I am struggling a bit — Extreme difficulty functioning

What are your goal(s) for therapy?_____

_____

How would you know things are improving?_____

_____

Please list anything else you would like me to know about you and questions you have for me…

_____

_____

_____

Thank you for taking the time to complete this Intake Form.
I look forward to meeting you!

Laurie