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

Individual Intake

How were you referred? ____________________

(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__________ Dates 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 Diso _____Physical Disability _____Learning Disability _____ADHD/ADD

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

_____Abuse: 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_______________________

Highest Level of Education____________________ Financial or Legal Problems__________________________

Religious affiliation as a child ______________________ Religious affiliation as adult______________________

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

____

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 Much/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**________________

Physical Symptoms **("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?____

____

____

Feel free to use the reverse side of page to complete responses as needed.

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

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