Anne Storelli, LPC, LMFT, PLLC

1709 Legion Rd., Suite 226, Chapel Hill, NC 27517 Ph:(919) 391-8915

anne.storelli.lpc.lmft@gmail.com

Adult Intake Form

Please answer the following questions as completely as possible.

Date_____

Patient (Client) Name_____

Address_____ City_____ State_____ Zip_____

Date of Birth ____/_____/_____ Age _____ Gender: Male __ Female __

Home Phone _____ May I leave a message? Yes No

Cell Phone _____ May I leave a message? Yes No

Work Phone _____ May I leave a message? Yes No

E-mail _____

Name of Employer _____ Occupation _____

Spouse/Partner's Name _____

Children's Names and Ages _____

In Case of Emergency notify:

Name_____ Relationship _____

Address_____ City _____ State_____ Zip_____

Work Phone_____ Home Phone _____ Cell Phone _____

Financial Guarantor Information (If other than self):

Name_____ Relationship _____

Address_____ City_____ State _____ Zip_____

Work Phone_____ Home Phone_____ Cell Phone_____

Insurance Company:_____ID#_____Group# _____

Policyholder_____ Policyholder's Date of Birth _____

Claims Address_____City _____ State _____ Zip _____

Employer _____ Copay, if known _____

Primary Care Physician: _____

Address _____ City/State/Zip _____

Phone _____ Fax _____

Referral Source: How did you find out about me?

Friend___ Insurance Co.___ Medical Professional___ Pastor___ Employer___ Internet___

Other_____

Religion _____

Church Affiliation (if any) _____

Pastor_____ Do your current difficulties affect your spirituality? Yes___ No___

What is the primary reason you are seeking help at this time? _____

_____

_____

_____

_____

_____

Adult Intake Questionnaire

Please check all that apply (if you have any questions about these, please ask for clarification):

[ ] Panicky feelings [ ] Fears [ ] Avoidance [ ] Procrastination [ ] Shyness

[ ] Driven to perform certain behaviors [ ] Nervous Tics [ ] Difficulties making decisions [ ] Flashbacks

[ ] Nightmares [ ] Feeling unreal [ ] Mood swings [ ] Anger problems [ ] Bingeing [ ] Purging

[ ] Loneliness [ ] Disorganization [ ] Seasonal variations of mood [ ] Mania [ ] Guilt

[ ] No sense of purpose [ ] Spiritual or religious concerns [ ] Sensitivity to noise and lights

[ ] Relationship problems [ ] Sexual problems [ ] Suspicious of others

[ ] Hearing unidentified sounds or voices

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling/staying asleep, sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not at all	Somewhat	Very difficult	Extremely difficult
In the past TWO years, have you felt depressed or sad most days, even if you felt okay sometimes?	Yes	No		

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:		
1. Have had nightmares about it or thought about it when you did not want to?	Yes	No
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	Yes	No
3. Were constantly on guard, watchful, or easily startled?	Yes	No
4. Felt numb or detached from others, activities, or your surroundings?	Yes	No

Mental Health History

Has anyone in your family had any of the following conditions? (check all that apply)

Depression__ Anxiety__ Suicide__ Bipolar Disorder__ Psychosis__ Alcoholism__ Substance Abuse__

If yes, please describe the family member's relationship to you and the problem:

Concern_____ Which relatives _____

Concern_____ Which relatives _____

Concern_____ Which relatives _____

Have you ever wanted to end your life? No__ Yes__ Have you ever attempted suicide? No__ Yes__

Do you currently have suicidal thoughts? No__ Yes__ Have you tried to harm yourself recently? No__ Yes__

Do you ever feel angry enough or out-of-control enough to do something you might regret? No__ Yes__

Do you have now or have you ever had thoughts of killing or seriously hurting someone else? No__ Yes__

In the past year, have you slapped, kicked, punched, or hurt anyone? No__ Yes__

Previous Counseling or Chemical Dependency Services:
Have you ever seen anyone or are you currently seeing anyone for:

Individual Therapy No__ Yes__ Marital/Couples Therapy No __ Yes__

Group Psychotherapy No__ Yes__ Sex Therapy No__ Yes__

Facility/Counselor Name	Month/Year Seen	Reason Seen	Helpful?
_____	_____	_____	No __ Yes__
_____	_____	_____	No__ Yes__

Past Hospitalizations (Psychiatric/Chemical Dependency)

Date(s)	Reasons	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you experienced any unusually severe stresses during the past year? No__ Yes__

If yes, please describe: _____

_____

_____

Medical/Lifestyle History

Current health: Poor__ Fair__ Good__ Excellent__

Do you have any medical problems or diseases? _____

_____

_____ _____

Did you ever have a head injury? Yes___ No___ Did you ever have a seizure? Yes___ No___

If yes, please describe _____

Do you exercise regularly? Yes___ No___ If yes, how many times per week? _____

Medications currently used:

Medication/Dose	When Prescribed	Why Prescribed	Prescribing Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you take any herbal medications? No___ Yes___ Please name _____

Alcohol Use:

How often do you use alcohol? None___ Monthly___ Weekly___ Daily___ Other _____

On the days that you drink, how many drinks do you usually have?

Less than 2____ 2-5____ 5 or more____

Do you consider it a problem? No___ Yes___ Do others consider it a problem? No___ Yes___

Do you have problems at work/school because of drinking or drug use? No___ Yes___

Have you had problems with alcohol in the past? No___ Yes___

Nicotine use:

Do you smoke or use tobacco now? No___ Yes___ If yes, how much/day? _____

Have you smoked or used tobacco in the past? No___ Yes___

Caffeine:

How many cups of caffeinated coffee/tea/soft drinks do you drink per day? _____

Drug use:

Marijuana: None___ Occasionally___ Weekly___ Daily___

Do you use other non-prescription substances? No___ Yes___ If yes, what substance?_____

Do you use prescription medication (esp. stimulants, opioids, or benzodiazepines) for other than prescribed purposes?)

No___ Yes___ If yes, what substance? _____

Legal History: None___ Litigation___ Arrest___ Victimization___ specify _____

Are you presently involved in a court case? No____ Yes____

Social History

Marital Status: Single___ Married___ Divorced___ Widowed___ Separated___

Number of years married: ____Total number of marriages: ____

How satisfied are you with your current family life?

Very Unsatisfied___ Unsatisfied___ Satisfied___ Very Satisfied___

How satisfied are you with the support you currently receive from your family and friends?

Very Unsatisfied___ Unsatisfied___ Satisfied___ Very Satisfied___

Have your current difficulties affected your family/friends/coworkers? No___ Yes___

Personal History

Which of the following best describes the family in which you grew up?

Warm and Accepting Average Distant, Hostile, and Fighting

1 2 3 4 5 6 7 8 9

Was your family/home/or adult life disrupted by serious illness/accident/death/divorce or other trauma?

No___ Yes___ If yes, please describe _____

_____

_____