

JAKE LEHRER, M.A., LMFT

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ADULT INTAKE FORM

Name: _____ Age: _____ Date: _____

Best phone # to contact you at: _____

Please answer these questions as completely as possible. You can discuss any topic more fully when you meet your therapist. It is your choice whether or not you answer any specific question(s). The purpose of this form is to help your therapist understand you, your background, and your concerns. THIS IS FOR YOUR THERAPIST ONLY.

Please describe the issue or concern that brings you to therapy, including specific symptoms or problems you MOST want to address:

Describe what you have already done to try and deal with your concerns.

Please complete by assigning a number to each problem listed, using the key below. Leave blank if you've never had the symptom. **Use space next to an issue to provide more information, if you wish.**

Do you have any of the following symptoms regularly or severely enough to cause you concern?

- | |
|--|
| <p>1 - In the past, but not now</p> <p>2 - Some of the time (current)</p> <p>3 - Most of the time (current)</p> <p>4 - All of the time</p> |
|--|

___ ADD or ADHD concerns (even if undiagnosed)

___ Adoption issues

___ Alcohol or chemical abuse/dependency

___ Anger issues

___ Anorexia/bulimia/eating issues (binging, under/over-eating)

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- | |
|--|
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|--|

- ___ Attempting suicide
- ___ Avoidance of conflict
- ___ Bi-polar concerns
- ___ Body issues
- ___ Childcare/parenting
- ___ Child development/behavior problems
- ___ Cigarette addiction
- ___ Codependency
- ___ Communication problems
- ___ Compulsive/addictive behavior
- ___ Concern about another's alcohol or chemical use
- ___ Cyber/internet sex/pornography, computer gaming or online issues (i.e. over-use, compulsivity)
- ___ Depression
- ___ Dissociation
- ___ Divorce/separation
- ___ Elder parent issues
- ___ Fear/sense of not being safe
- ___ Feeling ashamed
- ___ Feeling guilty
- ___ Feeling sad
- ___ Feeling suicidal
- ___ Financial problems/concerns

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- 1 - In the *past*, but not now**
- 2 - *Some* of the time (current)**
- 3 - *Most* of the time (current)**
- 4 - *All* of the time**

- ___ Gender identity concerns
- ___ Isolation
- ___ Jealousy
- ___ Legal problems
- ___ Loneliness
- ___ Loss of concentration
- ___ Loss of energy
- ___ Loss/grief issues
- ___ Low self-esteem
- ___ Marital/couple conflict
- ___ Mood swings
- ___ Neglect
- ___ Occupational/job problems
- ___ Parent/child issues
- ___ Physical health issues
- ___ Physically/sexually abused as an adult
- ___ Physically/sexually abused as a child
- ___ School-related problems
- ___ Self-hate/self-loathing
- ___ Self-injury
- ___ Sexual identity/orientation
- ___ Sexual relationship issues

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- 1 - In the *past*, but not now
- 2 - *Some of the time* (current)
- 3 - *Most of the time* (current)
- 4 - *All of the time*

- ___ Sexuality concerns
- ___ Single parenting issues
- ___ Step-family issues
- ___ Verbal/emotional abuse
- ___ Other – *please elaborate:*

Have your symptoms impacted your daily functioning or caused you any problems at school, work or home? Please describe:

How would you describe your psychological/emotional health at the present time?

- ___ Poor ___ Fair ___ Average ___ Good ___ Excellent

Comments:

Please describe any current or past significant stressors in your life (school, work, relationships, financial, etc.)

Are you aware of any family history of alcoholism, addiction, depression, anxiety, bi-polar, schizophrenia, or other mental illness? ___ Yes ___ No If yes, please describe:

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Chemical Health History (Alcohol, Illegal Substances, Non-Prescribed Substances, Tobacco, other)

Substance	Age When 1 st Tried	Date of most recent Use	Frequency of Use in Last Six Months (how often)	Amount Used Typically

Have there been any negative consequences as a result of your chemical use? i.e., DUI's, arrests, charges, relationship difficulties, etc. If yes, please describe.

Have others expressed concern about your alcohol or drug use? Yes No If yes, please describe:

Are you worried about the drug or alcohol use of a significant person in your life - i.e. spouse, parent, child, sibling? Yes No If yes, please describe your concern:

How do you identify your sexual orientation? _____

Are you: Single Married Divorced Widowed In a significant relationship

Comments:

Describe any comments or concerns regarding your living situation:

Legal History:

Have you had any current or past problems with the legal system? Please describe:

Are you currently involved in any legal action/litigation? Please describe:

Do the reasons you are seeking services at Lakewood have to do with legal issues? Please describe:

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Work/Education:

Occupation/Title: _____ Employer: _____

Comments:

How satisfied are you with your occupation and why?: _____

High School Attended: _____ Year of Graduation: _____

College/University: _____ Year of Graduation: _____

College/University: _____ Year of Graduation: _____

Degree(s) Earned and Major(s): _____

Interests/activities: Please describe interests or hobbies and how you spend time during a typical day.

Described your attributes that you consider to be strengths:

Described your attributes that you consider to be a source of weakness, frustration or concern (for you or others):

How would you describe your *physical* health at the present time?

____ Poor ____ Fair ____ Average ____ Good ____ Excellent ____ Not sure

Medical Information:

Name of Primary Physician: _____ Phone:# _____

Name of Clinic: _____

Date and Reason of Last Physical Exam _____

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Current Medication(s)

Name	Dosage	Prescriber/Clinic	Date(s)

Do you take your medications regularly? If not, please explain, e.g., how often you miss doses:

Previous Medication(s)

Name	Dosage	Prescriber/Clinic	Date(s)

Previous Therapist(s)

Name/Clinic	Date(s)	Comment(s)

What HAS worked for you in therapy? Describe:

What has NOT worked for you in therapy? Describe:

Over →

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Previous Hospitalizations, Partial Hospitalizations, Day Treatments, CD Treatments, etc

Name/Clinic/Facility	Date(s)	Comment(s)

Have you experienced any significant illnesses, accidents or surgeries? Please describe:

Describe the physical fitness program you follow, if any:

Spiritual/Religious Belief System:

Do you actively participate in a spiritual/faith community? Yes No

If yes, please identify/describe that community:

How important is your faith to you?

What kind of a support system do you have?

Is there anything more that you want to share?

THANK YOU

Signature _____

Date _____