FLORIDA LIGHTHOUSE
COUNSELING CENTER

INTAKE FORM

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Referred by:

- Medical Provider: _____
- Insurance Provider: _____
- My Website: http://www.fllighthousecc.com
- PsychologyToday
- Friend/Family: _____
- Other: _____

Have you previously received any type of mental health services? **Yes** **No**

If yes, which of the following:

- Psychotherapy
- Medication
- Outpatient Hospitalizations
- Inpatient Hospitalization

If yes, please provide:

Name of provider or facility:_____

Location:_____

Dates of treatment:_____

Reason for treatment:_____

Briefly, what brings you in today? _____

When did your problem first start?

- Within the last: 30 days
- 6--12 months
- 2 years
- During adolescence
- During childhood

What areas of your life have been affected because of this problem?

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_____

_____

Are you currently experiencing overwhelming sadness, grief or depression? **Yes** **No**

If yes, for approximately how long? _____

Are you currently experiencing thoughts of suicide or desire to die, not being here? **Yes** **No**

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias? **Yes** **No**

If yes, when did you begin experiencing this? _____

Please describe any major losses or traumas you have experienced:

_____

_____

What significant life changes or stressful events have you experienced recently?

_____

_____

What would you like to accomplish out of your time in therapy

_____

_____

Family History

Where were you born? _____

Where did you grow up? _____

- City _____
- Suburbs _____
- Country _____

Please list your parents and siblings.

Name	Age	Relationship	Where do they live now?	If deceased, age and cause of death

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Who did you live with while growing up? _____

Mother's occupation: _____

Father's occupation: _____

In the section below identify if there is a family history of any of the following.

If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Condition	**Please Circle**	**List Family Member**
Alcohol/Substance Abuse	Yes / No	
Anxiety	Yes / No	
Depression	Yes / No	
Domestic Violence	Yes / No	
Sexual Abuse	Yes / No	
Eating disorder	Yes / No	
Obesity	Yes / No	
OCD	Yes / No	
Schizophrenia	Yes / No	
Suicide attempts	Yes / No	
Other diagnosed mental health condition?	Yes / No	Diagnosis

Marital Status:

- Never Married
- Domestic Partner
- Married
- Separated
- Divorced -- For how long?
- Widowed: Please provide your partners name and year deceased:

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_____

- If married, how long have you been married for and what is your partners name:

_____

On a scale of 1-10 (best), how would you rate your relationship? _____

Are you currently in a romantic relationship? **Yes** -- How long? _____ **No**

On a scale of 1-10 (best), how would you rate your relationship? _____

Please list any children, their names, and ages:

Name	Age	Relationship	Name of other parent	If deceased, age and cause of death

Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement	Dosage	Condition	Date Began/Stopped

Prescribing provider and contact information:

Name: _____

Specialty: _____

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Facility: _____

Phone, email, or Fax: _____

How would you rate your current physical health?

- Poor
- Unsatisfactory
- Satisfactory
- Good
- Very Good

Please list any specific health problems you are currently experiencing:

_____

How would you rate your current sleeping habits?

- Poor
- Unsatisfactory
- Satisfactory
- Good
- Very Good

If you are having problems, in which phase of sleep are you experiencing issues?

- Falling asleep
- Staying asleep
- Awakening early
- Sleep apnea

Please list any other specific sleep problems you are currently experiencing:

_____

How many times per week do you generally exercise? _____

What types of exercise do you participate in:

_____

Are you currently experiencing any chronic pain? **Yes No**

If yes, please describe: _____

Please describe current use of alcohol, cigarettes, and/or recreational drugs:

_____

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Please describe previous use of alcohol, cigarettes, and/or recreational drugs:

_____

Additional Information

What do you enjoy about your work (full-time homemaker included)?

_____

If retired, what did you enjoy about your work?

_____

What do you find particularly stressful about your current or previous work?

_____

What do you enjoy doing in your free time?

_____

What do you do to relax?

_____

Do you consider yourself to be spiritual or religious?

_____

If yes, please describe your faith or belief:

_____

What do you consider to be some of your strengths?

_____

What do you consider to be some of your weakness?

_____