Laurie Estey, LMHC
Intake

Please print and bring intake to first appointment.

Personal Information

Date: _____

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if you are a minor):
_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status:
□ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Number of Children: _____

Local Address: _____
(Street and Number)
_____
(City) (State) (Zip)
Home Phone: ( ) - May I leave a msg? □Yes □No
Cell/Other Phone: ( ) - May I leave a msg? ☐Yes ☐No
Work Phone: ( ) -May I leave a msg? ☐Yes ☐No

E-mail: _____

May I E-mail you? □Yes □No
Signature _____Date_____

Insurance Company

PLEASE COPY YOUR INSURANCE CARD AND BRING TO YOUR APPOINTMENT!

Insurance company: _____

Do you have a HMO or PPO? _____

Is preauthorization needed? _____ How many visits are authorized? ____

Policy Number: _____Group Number: _____

Co-Pay: _____

Please note: If preauthorization is required by your insurance company(s) and has not been done, you will be responsible for payment in full of your initial visit and subsequent visits.

If you are not the policy holder, please complete the following:

Name of Policy Holder:_____

*Relation to Policy Holder:*_____

Address of Policy Holder: _____City:_____Zip:_____

Birth date of Policy Holder: _____

Place of employment of Policy Holder:_____

Name of Additional Insurance (if applicable):_____

*Do I have your permission to discuss financial matters with the policy holder above:_____

Referred by: _____

Emergency Contact Information

Name: _____Phone #_____

Relation: _____

Are you currently receiving psychiatric services, professional counseling or psychotherapy?
Elsewhere? □Yes □No

Have you had previous psychotherapy?
□No
□Yes, at previous therapist's name_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
□Yes
□No

If yes, please list: _____

_____

*Prescribing Physician-Name and Phone Number:

_____

If no, have you been previously prescribed psychiatric medication?
□Yes □No
If yes, please list: _____

_____

Have you ever been hospitalized for any reason? If yes, please explain and give dates:
_____

HEALTH AND SOCIAL INFORMATION

How is your health? Please circle one.

Poor Good Excellent

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):
_____

_____

Are you having any problems with your sleep habits? □ No □ Yes

If yes, check where applicable:
□ Sleeping too little □ Sleeping too much □ Poor quality sleep
□ Disturbing dreams □ Other _____

How many times per week do you exercise? _____
Approximately how long each time? _____

Are you having any difficulty with appetite or eating habits? □ No □ Yes
If yes, check where applicable:
□ Eating less □ Eating more □ Binging □ Restricting

Have you experienced significant weight change in the last 2 months?
□ No □ Yes

Do you regularly use alcohol? □ No □ Yes
In a typical month, how often do you have 4 or more drinks in a 24-hour period?

_____

How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly □ Rarely □ Never

Have you had suicidal thoughts recently?
□ Frequently □ Sometimes □ Rarely □ Never

Have you had them in the past?
□ Frequently □ Sometimes □ Rarely □ Never

Are you currently in a romantic relationship? □ No □ Yes
If yes, how long have you been in this relationship? _____
On a scale of 1-10, how would you rate the quality of your current relationship? _____

In the last year, have you experienced any significant life changes or stressors?
_____
_____
_____
_____
_____
_____

Have you ever experienced?

Extreme depressed mood	yes/no
Wild Mood Swings	yes/no
Rapid Speech	yes/no
Extreme Anxiety	yes/no
Panic Attacks	yes/no
Phobias	yes/no
Sleep Disturbances	yes/no
Hallucinations	yes/no
Unexplained losses of time	yes/no
Unexplained memory lapses	yes/no
Alcohol/Substance Abuse	yes/no
Frequent Body Complaints	yes/no
Eating Disorder	yes/no
Body Image Problems	yes/no
Repetitive Thoughts (e.g., Obsessions)	yes/no
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing)	yes/no
Homicidal Thoughts	yes/no
Suicide Attempt	yes/no

OCCUPATIONAL INFORMATION:

Are you currently employed? □ No □ Yes

If yes, who is your current employer/position? _____

If yes, are you happy at your current position? _____

Please list any work-related stressors, if any:
_____

_____

RELIGIOUS/SPIRITUAL INFORMATION:
Do you consider yourself to be religious/spiritual? □ No □ Yes
If yes, what is your faith?
_____

If no, do you consider yourself to be spiritual? □ No □ Yes

FAMILY MENTAL HEALTH HISTORY:
Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following?
(Circle any that apply and list family member, e.g. Sibling, Parent, Uncle, etc.):

Difficulty	**Family Member**
Depression	yes/no
Bipolar Disorder	yes/no
Anxiety Disorders	yes/no
Panic Attacks	yes/no
Schizophrenia	yes/no
Alcohol/Substance Abuse	yes/no
Eating Disorders	yes/no
Learning Disabilities	yes/no
Trauma History	yes/no
Suicide Attempts	yes/no

What brings you here today?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

OTHER INFORMATION:
What do you consider to be your strengths?

What do you like most about yourself?

What are effective coping strategies that you've learned?

What are your goals for therapy?