ORION CROOK, MA, LPC
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CONFIDENTIAL ADULT INTAKE

PERSONAL INFORMATION:
My name is:_____ Date:_____
Address:_____
City:_____
Zip Code:_____
Home Phone: _____ May we call? Y/N Leave messages? Y/N
Cell Phone: _____ May we call? Y/N Leave messages? Y/N
Email:_____
Date of birth: _____ Age: _____
I currently live with:_____
Relationship(s) to me:_____
I am here because:_____
My strengths are:_____
My interests are/ I enjoy:_____
Gender: ☐ male ☐ female ☐ mtf ☐ ftm ☐ queer ☐ other:_____
My sexual orientation is: ☐ Heterosexual ☐ Bisexual ☐ Gay ☐ Lesbian ☐ Queer ☐
other:_____
Emergency Contact:_____ Phone: _____
Relationship to Emergency Contact Person:_____
How did you hear about Orion Psychotherapy?_____

INSURANCE:
Insurance Provider: _____

Individual Number: _____

Type of Insurance (if known): _____
Co-Pay: _____
Deductible: _____

As far as you know have you met any of the deductible:_____

Credit Card on File (this will be secured with other documents in a locked drawer and used for missed sessions):

Type of card:_____ Card #_____

Name and Zip code of card:_____ _____

Expiration and Code on Back:_____ _____

MENTAL HEALTH HISTORY:
Previous therapy counseling (when with whom):_____
Any mental health issues (list and describe, previous diagnoses, including any course of treatment):_____
Psychotropic Medications currently used (name, dosage, length of time taking it, side effects experienced):
_____

_____
Psychotropic Medications previously used (name, dosage, length of time taking it, side effects experienced): _____

_____

Current Psychiatrist (name, address, #):_____

VOCATION (fill out for parents for under 18):
I am employed: ☐ Yes ☐ No
My title is:_____ I am employed with:_____
I have worked there for: _____
Salary per year/month:_____
My job has been impacted by my presenting concerns: ☐ Yes ☐ No
If Yes, please explain:_____

LEGAL HISTORY:
I have been involved with the legal system: ☐ Yes ☐ No
If Yes, please explain:_____
Is you seeing a therapist required/recommended by the courts/attorney: : ☐ Yes ☐ No

PRESENTING CONCERNS:
Are you experiencing any symptoms that have been a concern for more than four weeks and get in the way of you living life? ☐ Yes ☐ No
If Yes, please list which symptoms:_____

☐ Low energy
☐ Low self-esteem ☐ Poor concentration
☐ Thoughts of suicide ☐ Hopelessness
☐ Loneliness ☐ Worthlessness
☐ Depressed ☐ Isolation/social withdrawal
☐ Sadness/loss ☐ Thoughts of hurting yourself
☐ Guilt ☐ Don't like weekends and vacations
☐ Sleep disturbance ☐ Appetite disturbance
☐ Stress ☐ Thoughts of hurting someone else
☐ Anxiety/panic ☐ Heart pounding/racing
☐ Chest pain ☐ Trembling/shaking
☐ Chills/hot flashes ☐ Tingling/numbness
☐ Fear of dying ☐ Fear of going crazy
☐ Nausea ☐ Phobias
☐ Racing thoughts ☐ Obsessions/compulsive behaviors
☐ Headaches ☐ Palpitations
☐ Bowel disturbances ☐ Nightmares
☐ Feel tense ☐ Unable to relax
☐ Can't make friends ☐ Can't keep a job
☐ Financial problems ☐ Excessive sweating
☐ Dizziness ☐ Stomach trouble
☐ Fatigue/exhaustion ☐ Take sedatives
☐ Feel panicky ☐ Conflict

Check all that apply to you:

☐ Sexual problems ☐ Spousal abuse concerns ☐ Blaming others
☐ Overambitious ☐ Inferiority feelings ☐ Excessive use of drugs
☐ Memory problems ☐ Fainting spells ☐ Excessive use of prescription medications
☐ Reproductive concerns ☐ Alcoholism ☐ Blackouts
☐ Insomnia ☐ Shy with people ☐ Avoiding others
☐ Tremors ☐ Unable to have a good time ☐ Crying spells
☐ Allergies ☐ Can't make decisions ☐ Paranoia/distrust
☐ Home conditions bad ☐ Easily startled ☐ Eating concerns (binging, purging, restricting)
☐ Concentration difficulties ☐ Self criticism ☐ Mood fluctuations
☐ Work problems ☐ Not thinking clearly/confusion ☐ Feel out of control
☐ Excessive drinking ☐ Delusions/hallucinations ☐ Self injury
☐ Can't hold onto an idea ☐ Feeling that you are not real ☐ Excessive behaviors (spending, gambling)
☐ Lose track of time ☐ Feeling that things around you are not real
☐ Anger/frustration ☐ Unpleasant thoughts that won't go away
☐ Easily agitated/annoyed ☐ Defying rules ☐ Other:_____

Three Goals for therapy (leave for us to do in session):
1

2.

3.