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(s): _______________________________
My sexual orientation is:_________________
Pronoun(s): ______________________

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: _____________

Are you seeking Out of Network monthly receipts? Y/N

After the first session you will receive a text from IVY Pay to put in your CC information.

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

<u>Check all that apply to you:</u>

☐ Sexual problems
☐ Overambitious
☐ Memory problems
☐ Reproductive concerns
☐ Insomnia
☐ Spousal abuse concerns
☐ Inferiority feelings
☐ Fainting spells
☐ Alcoholism
☐ Shy with people
☐ Blaming others
☐ Excessive use of drugs
☐ Excessive use of prescription medications
☐ Blackouts
☐ 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:

1

2.

3.