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: _____

PAYMENT:

After the first session you will receive a text from IVY Pay to put in your CC information (3 dollar fee) or you can Zelle me at OrionPsychotherapy@gmail.com. Please Zelle while in the waiting room as a way to not forget once you leave session.

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, #):_____

If you would like me to be able to talk with them, please fill out a Release of Information available on my website under the forms tab.

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? σ Yes σ No

If Yes, please list which symptoms:_____

σ Low energy

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

Check all that apply to you:

σ Sexual problems	σ Spousal abuse concerns	σ Blaming others
σ Overambitious	σ Inferiority feelings	σ Excessive use of drugs
σ Memory problems	σ Fainting spells	σ Excessive use of prescription medications

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

Three Goals for therapy:

1

2.

3.