ORION CROOK, MA, LPC, LMHC
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CONFIDENTIAL ADULT INTAKE

PERSONAL INFORMATION:

My legal name is:_____ Date:_____

My preferred name is:_____

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 if you choose to bill your credit card you will receive a text from IVY Pay to put in your CC information (with a 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 the session. We may have explored other payment options as well.

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? ☐ 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:

1.

2.

3.

If you would like please draw and image below that represents you regarding the reasons that are bringing you to therapy and/or just the reasons/symptoms that are you to seek therapy to treat: