Elizabeth (Liz) Seau LCSW, LLC

1601 2nd Ave North, Suite 100-A – Great Falls Montana, 59401 – 406-616-3857

Intake Form

Please provide the following information and answer the questions below. Please note: *information you provide here is protected as confidential information.* Please fill out this form and bring it to your first session. Also, please have your insurance card/s with you for the first session.

Patient Information

Patient Name:

_____

(Last) (First) (Middle Initial)

**If under 18 years old* - Name of parent/ guardian of patient:

_____

(Last) (First) (Middle Initial)

Patient Social Security # _ _ _ - _ _ - _ _ _ _ Birth Date: _ _ / _ _ / _ _ Age: _____

Address:

_____

Street City State Zip

Mailing address if different from above: _____

Home Phone: ( ) May we contact you or leave a message? Yes No

Cell/Other Phone: ( ) May we contact you or leave a message? Yes No

E-Mail: _____ May we email you? Yes No

*** Please note: Email correspondence is not considered to be a confidential medium of communication.*

If no contact is requested, please explain: _____

I was referred by: _____

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Emergency Contact for patient:

_____(____)_____

First and last name Relationship Phone Number

Insurance Information:

Policy Holder Name: _____ Birth date: _____

Address (if different from client) _____

Medical Insurance Company _____ Employer_____

EAP/Mental Health Company (if different from above) _____

Insurance ID number or Social Security Number (if EAP or Private Pay): _____

Relationship to Client _____

Is there secondary Insurance? _____

Please complete if client is a minor:

Father's Name _____ Social Security Number _____

Father's Address _____ Phone Number _____

Employer _____ Date of Birth _____ Work Phone _____

Mother's Name _____ Social Security Number _____

Mother's Address _____ Phone Number _____

Employer _____ Date of Birth _____ Work Phone _____

List name and phone number of Primary Care Physician (PCP):

_____

By signing below, ***I AUTHORIZE THE RELEASE OF INFORMATION*** necessary to process my insurance/ EAP/ managed care/ DDS claim and ***I ACKNOWLEDGE FINANCIAL RESPONSIBILITY*** for this account.

CLIENT SIGNATURE _____ DATE_____

AUTHORIZED SIGNATURE FOR A MINOR _____ DATE_____

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Name_____ Date of Birth _____

PRESENTING PROBLEM:
I am seeking help for (please circle all that apply):

Anxiety Alcohol problem Depression Domestic violence/Abuse

Drug problem Gambling problem Trauma/Abuse Job problems

Legal problems Relationship problems School problems Not sure Other

Brief description: _____

Impact on functioning: _____

BACKGROUND INFORMATION

IDENTIFICATION:
Currently: Never Married Domestic Partnership Married Separated Divorced Widowed

If applicable, how long have you been in your current relationship? ____ Months ____ Years

On a scale of 1 – 10, circle satisfaction with current relationship:
(low satisfaction) 0 1 2 3 4 5 6 7 8 9 10 *(high satisfaction)*

Please give name, age and sex for each of your children: ◯ No children

Name of each child:			
Age:			
Sex:			
Biological:			
Step-child:			
Custody status:			

Race/Ethnicity: _____ ○ I choose not to answer

Do you believe anything in your cultural background would create a barrier to treatment?

○ Yes ○ No

Brief description: _____

Do you consider yourself to be spiritual or religious? ○ No ○ Yes, Religion/Belief:

_____

Gender: ○ Male ○ Female ○ Androgynous ○ Gender neutral ○ Transgender

○ Other ○ Prefer not to answer

HISTORY OF PRESENTING PROBLEM:

What significant life changes or stressful events have you experienced recently: _____

_____

Mild = Impacts quality of life, but no significant impairment of day-to-day functioning
Moderate = Significant impact on quality of life and/or day-to-day functioning
Severe = Profound impact on quality of life and/or day-to-day functioning

Symptoms unchecked will be considered not applicable.

Patient's *current* symptoms. Please check √ all that apply:	Mild	Moderate	Severe	Symptoms continued. Please check √ all that apply:	Mild	Moderate	Severe
Aggressive behaviors				Laxative/diuretic abuse			
Agitation/Irritability				Lightheaded			
Anger				Loss of touch with reality			
Anorexia				Low esteem			
Anxiety (generalized)				Mood swings			
Appetite disturbance				Muscle tension			
Bingeing/purging				Nausea			
Circumstantial symptoms				Nightmares			
Conduct problems				Obsessions/Compulsions			
Delusions				Oppositional behavior			
Depressed mood				Overly talkative			
Perception/sensations of world seems unreal				Panic attacks			
Difficulty making decisions				Paranoid thinking			
Dizziness				Phobias (fears)			
Elevated mood (Mania)				Poor hygiene			
Elimination (toileting) disturbance				Psychomotor retardation			
Emotionality				Related medical conditions			
Fatigue/low energy				Restlessness			
Feeling of choking				Seeking excessive pleasure			
Flashbacks				Self-mutilation			
Racing/Rapid thoughts				Sexual dysfunction			
Forgetfulness				Significant weight gain/loss			
Grief				Sleep disturbance			
Guilt				Social isolation			
Hallucinations				Somatic complaints			
Hopelessness				Tremble or shake			
Hyperactivity				Trouble concentrating/Distractibility			
Impulsiveness				Trouble with daily living activities			
Intrusive thoughts				Worthlessness			
Invincibility							

Symptoms unchecked will be considered not applicable.

PAST PSYCHIATRIC HISTORY:

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

◯ No ◯ Yes, name of your *Psychiatrist/Psychologist*? _____

FAMILY HISTORY:

Describe your childhood family experience:

◯ Outstanding home environment
◯ Normal home environment
◯ Chaotic home environment
◯ Witnessed physical/verbal/sexual abuse toward others
◯ Experienced physical/verbal/sexual abuse from others

People in your family who were important as you grew up: _____

Father: ◯ Living ◯ Deceased How do you get along? _____

Mother: ◯ Living ◯ Deceased How do you get along? _____

Siblings and how do you get along: _____

FAMILY PSYCHIATRIC HISTORY:

Mental health history. Please check all that apply:	**Self (Patient)**	Mother	Father	Siblings	Maternal Grandparents	Paternal Grandparents	Maternal Aunts/Uncles	Paternal Aunts/Uncles
Alcohol/Substance Abuse								
Anxiety								
Behavioral Problems								
Dementia								
Depression								
Domestic Violence								
Eating Disorder								
Emotional Problems								
Gambling Addictions								
Mental Retardation								
Obsessive Compulsive Disorder (OCD)								
Schizophrenia								
Suicide Attempts								
Other Mental Illness								

MEDICAL CONDITIONS & HISTORY:

How would you rate your current physical health? ○ GOOD ○ FAIR ○ POOR

Medical History: In the section below, identify if there is a history of any of the following:

Medical health history. Please check all that apply:	**Self (Patient)**	Mother	Father	Siblings	Grandparents	Paternal Grandparents	Maternal Aunts/Uncles	Paternal Aunts/Uncles
Allergic reaction								
Alzheimer's								
Birth defects								
Cancer								
Diabetes								
Heart disease								
High blood pressure								
Obesity								
Stroke								
Thyroid problems								
Tobacco use								
Tuberculosis								
Chronic pain								
Other* chronic or serious health issue								

If other*, please provide any important information or history:

_____

_____

Please describe any significant illnesses, hospitalizations or accidents you have had:

_____

_____

_____

Please list any specific health problems you are currently experiencing:

_____

_____

CURRENT MEDICATION:

Please provide a current list/copy of all medications or complete the following:

Have you ever been ***prescribed psychiatric*** medication? ○ No ○ Yes if yes, please list information:

Medication	Dosage	Frequency	Reason	Prescribing Doctor

Are you currently taking **any *prescription*** medication? ◯ No ◯ Yes if yes, please list information:

Medication	Dosage	Frequency	Reason	Prescribing Doctor

SUBSTANCE USE/ABUSE:

How often do you engage in recreational (illicit/non-prescribed) drug use?

◯ Never ◯ Infrequently ◯ Monthly ◯ Weekly ◯ Daily

SOCIAL HISTORY:

My social support system is: ◯ a supportive network ◯ few or no friends ◯ substance abuse friends ◯ distant from family of origin

My living/housing situation is: ◯ Adequate ◯ Overcrowded ◯ Homeless ◯ Dependent on others ◯ Dangerous/deteriorating ◯ Living companion(s) are dysfunctional

My financial situation includes: ◯ No problems ◯ Large indebtedness ◯ Poverty or below-poverty income ◯ Impulsive spending ◯ Relationship conflicts over finances

Sexual orientation? ◯ Bisexual ◯ Gay ◯ Lesbian ◯ Straight/Heterosexual ◯ Other ◯ Prefer not to answer

Are you currently sexually active? ◯ Yes ◯ No ◯ I use protection/birth control

Sexually ◯ Satisfied ◯ Dissatisfied

EDUCATIONAL/OCCUPATIONAL HISTORY:

Current Employment: ◯ Full-time ◯ Part-time ◯ Unemployed ◯ Volunteer work ◯ Homemaker ◯ Student

Current or highest education level completed: K 1 2 3 4 5 6 7 8 9 10 11 12 ◯ GED

◯ Some college ◯ College degree completed: _____ ◯ Other: _____

Current School or College (if applicable): _____

Grades achieved were: ◯ GOOD ◯ FAIR ◯ POOR

Name of Employer (if applicable) _____

On a scale of 1 – 10, circle current job satisfaction: *(low satisfaction)* 0 1 2 3 4 5 6 7 8 9 10 *(high satisfaction)*

Describe the work you do: _____

Length of employment: _____

Relationship with co-workers(s): ◯ GOOD ◯ FAIR ◯ POOR

Relationship with Supervisor(s): ◯ GOOD ◯ FAIR ◯ POOR

Do you enjoy your work? Is there anything stressful about your current work? _____

◯ Served in military ◯ no-incident ◯ with incident Branch _____

LEGAL HISTORY:

Have you ever been arrested? ◯ No ◯ Yes – if yes, please provide details:

◯ Arrest(s) NOT substance related, how many times? _____ ◯ Non-violent ◯ Violent

◯ Arrest(s) substance related, how many times? _____

◯ I am currently on probation/parole

◯ I am currently in drug court

◯ My charge was related to a domestic violence offense

◯ I have served time in jail/prison. Total time served? _____

STRENGTHS:

What do you consider your strengths? _____

LIMITATIONS:

What do you consider your Limitations? _____

What would you like to accomplish or set as a goal(s) to achieve in therapy? _____

_____

_____

As the therapist, I have reviewed and discussed the information provided by the client above and I have clarified information and requested additional details when necessary to provide therapy.

_____ _____

Therapist signature Therapist printed name