

New psychotherapy clients: Please print out, fill out and bring in for your first appointment, thanks.

INTAKE INFORMATION for counseling and psychotherapy at *theZenter*

Today's date (Case ID) : \_\_\_\_\_

GENERAL INFORMATION (client or parent):

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Town/City: \_\_\_\_\_ State \_\_\_\_\_ zip code: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
SS#: \_\_\_\_\_ Home phone: \_\_\_\_\_  
Business phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ *If it is ok for us to call you and leave a message. Please circle the number we may use.*  
Race: \_\_\_\_\_ Gender: Female Male Age: \_\_\_\_\_ Educational level: Elementary \_\_\_  
GED \_\_\_ High School \_\_\_ College \_\_\_ Graduate school \_\_\_  
Emergency contact person: \_\_\_\_\_ Relationship to you: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ zip \_\_\_\_\_  
Phone: \_\_\_\_\_  
Primary Care Physician (PCP): \_\_\_\_\_ Address: \_\_\_\_\_  
Phone nr: \_\_\_\_\_ Do we have your permission to disclose information to your PCP ? Yes No

How did you hear about this office/this practitioner? \_\_\_\_\_  
May we acknowledge the referral? Yes no

EMPLOYMENT:

Employer or school: \_\_\_\_\_ Length of time with current employer \_\_\_\_\_ Job title \_\_\_\_\_  
Division \_\_\_\_\_ Shift \_\_\_\_\_ Job Category: Mgmt \_\_\_ Profess \_\_\_ Tech \_\_\_  
Admin \_\_\_ Skilled \_\_\_ Unskilled \_\_\_

FAMILY:

Marital/Legal status (please circle): Single, Married, divorced, Widowed.  
If Married, is this your first marriage? Y, N. How long have you been married? \_\_\_\_\_  
Spouse/Significant other: Name \_\_\_\_\_ Age \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer: \_\_\_\_\_  
How would you describe this person? \_\_\_\_\_  
Children (if applicable): Describe child:  
Name: \_\_\_\_\_ age: \_\_\_\_\_ Gender \_\_\_\_\_  
Name: \_\_\_\_\_ age: \_\_\_\_\_ Gender \_\_\_\_\_  
Name: \_\_\_\_\_ age: \_\_\_\_\_ Gender \_\_\_\_\_  
Name: \_\_\_\_\_ age: \_\_\_\_\_ Gender \_\_\_\_\_  
Mother: Living Y N If yes, age \_\_\_\_\_ number of times married \_\_\_\_\_  
Describe mother: \_\_\_\_\_  
Father: Living Y N If yes, age \_\_\_\_\_ number of times married \_\_\_\_\_  
Describe father: \_\_\_\_\_

INITIAL EVALUATION (client or parent information)  
*Please fill out what you have answers to and skip the rest.*

What are you experiencing that led you to make this appointment? \_\_\_\_\_

Has this been a problem before? Y N, please elaborate: \_\_\_\_\_

What do you wish to change in your life? \_\_\_\_\_

What do we need to know to best help you? \_\_\_\_\_

Is your problem impacting your job performance Y N

HISTORY (client information):

Have you ever been in counseling/psychotherapy/support group? Y N. When? \_\_\_\_\_

With whom? \_\_\_\_\_. When was this terminated? \_\_\_\_\_. Why was it terminated? \_\_\_\_\_

Were previous treatment interventions helpful? Y N. Elaborate please: \_\_\_\_\_

Have you ever been hospitalized for emotional difficulties? Y N. If yes, when? \_\_\_\_\_

Where? \_\_\_\_\_. Who was your treating physician? \_\_\_\_\_

Are you currently being seen by another behavioral health clinician? \_\_\_\_\_

If you have used, when was the approximate last date you used: Caffeine: \_\_\_\_\_

Tobacco: \_\_\_\_\_ Alcohol: \_\_\_\_\_ Marijuana: \_\_\_\_\_ Stimulants: \_\_\_\_\_

Narcotics: \_\_\_\_\_ Cocaine: \_\_\_\_\_ Other: \_\_\_\_\_

Has anyone in your family ever had an alcohol or other drug problem? \_\_\_\_\_

Has anyone ever expressed concern about your own alcohol or other drug usage? \_\_\_\_\_

Is there any history of physical or sexual abuse in your family? \_\_\_\_\_

Have any family members had psychological or emotional issues Y N

If Yes, who? \_\_\_\_\_ When? \_\_\_\_\_ For how long? \_\_\_\_\_

Please include information about any known prenatal and perinatal events (events in the lives of you and your parents before and during your birth): \_\_\_\_\_

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Relevant psychological and social conditions affecting your medical and psychiatric status at present \_\_\_\_\_

GENERAL HEALTH:

Do you exercise? Y N How often and what kind? \_\_\_\_\_

When was your last physical? \_\_\_\_\_ Are you under the care of a physician?

Y N, If yes, who? \_\_\_\_\_ What are you being treated for?

\_\_\_\_\_ May we disclose information to this physician? Y N

If yes, Address of physician: \_\_\_\_\_ phone: \_\_\_\_\_

Medications taken regularly? Y N. If yes, name and dosage: \_\_\_\_\_

What for? \_\_\_\_\_

Date of initial prescription or refills: \_\_\_\_\_ Over-the-counter meds: \_\_\_\_\_

Do you have any chronic physical problems? \_\_\_\_\_  
List major injuries \_\_\_\_\_ surgeries \_\_\_\_\_  
illnesses \_\_\_\_\_ Allergies and adverse reactions, or sensitivities,  
to foods, drugs and other substances? \_\_\_\_\_,  
or no known allergies (NKA) \_\_\_\_\_. Do you have any infectious diseases? \_\_\_\_\_

#### HAVE YOU RECENTLY EXPERIENCED ANY OF THE FOLLOWING?

<input type="checkbox"/> loss of interest	<input type="checkbox"/> loss of appetite	<input type="checkbox"/> racing heart	<input type="checkbox"/> shortness of breath
<input type="checkbox"/> dizziness	<input type="checkbox"/> too much sleep	<input type="checkbox"/> inability to enjoy life	<input type="checkbox"/> increased appetite
<input type="checkbox"/> trembling	<input type="checkbox"/> insomnia	<input type="checkbox"/> fainting	<input type="checkbox"/> fatigue
<input type="checkbox"/> choking	<input type="checkbox"/> dry mouth	<input type="checkbox"/> feeling worthless	<input type="checkbox"/> diarrhea
<input type="checkbox"/> fear of dying	<input type="checkbox"/> nausea	<input type="checkbox"/> trouble thinking	<input type="checkbox"/> pressure in chest
<input type="checkbox"/> vomiting	<input type="checkbox"/> fear of travel	<input type="checkbox"/> arm/leg pain	<input type="checkbox"/> feeling keyed up
<input type="checkbox"/> hot flashes	<input type="checkbox"/> angry outbursts	<input type="checkbox"/> loss of weight	<input type="checkbox"/> fear of 'going crazy'
<input type="checkbox"/> fears	<input type="checkbox"/> nightmares	<input type="checkbox"/> easily startled	<input type="checkbox"/> poor concentration
<input type="checkbox"/> chills	<input type="checkbox"/> flashbacks	<input type="checkbox"/> feeling on edge	<input type="checkbox"/> numbness/tingling
<input type="checkbox"/> chest pain	<input type="checkbox"/> painful periods	<input type="checkbox"/> smothering	<input type="checkbox"/> loss of energy
<input type="checkbox"/> sweating	<input type="checkbox"/> low self-esteem	<input type="checkbox"/> irritability	<input type="checkbox"/> lump in throat
<input type="checkbox"/> forgetfulness	<input type="checkbox"/> restlessness	<input type="checkbox"/> feeling hopeless	<input type="checkbox"/> sudden/intense anxiety
<input type="checkbox"/> racing thoughts	<input type="checkbox"/> gaining weight	<input type="checkbox"/> think too much	<input type="checkbox"/> feeling smothered
<input type="checkbox"/> feeling sad	<input type="checkbox"/> crying	<input type="checkbox"/> increased night dreams	<input type="checkbox"/> general anxiety
<input type="checkbox"/> thoughts of harming self or others		<input type="checkbox"/> waking up frequently during sleep	
<input type="checkbox"/> difficulties falling asleep		<input type="checkbox"/> my pain medication stopped working	
<input type="checkbox"/> feeling like I have to do the same thing repeatedly			

#### RESOURCES:

To whom do you turn for strength? \_\_\_\_\_  
Tell us about your support systems if you have such \_\_\_\_\_

Some people have religious practices that offer support, do you have such practices? \_\_\_\_  
please elaborate: \_\_\_\_\_

What have you done in the past to assist you in times of crisis? \_\_\_\_\_

What are the health, wellness and leisure practices that you routinely participate in? \_\_\_\_\_

Where were you born? (state, county, country) \_\_\_\_\_

Where is your family from? \_\_\_\_\_. Original origin of family: (I.e. England, Denmark)

Father's side \_\_\_\_\_ Mother's side \_\_\_\_\_

#### LEGAL HISTORY:

Have you ever been convicted of a felony offence? \_\_\_\_\_ If yes, please elaborate \_\_\_\_\_

Thank you, please return this form to Inge Mula Myllerup-Brookhuis Cand.Psych. LPC, CEAP

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FOR OFFICE USE:

DSM IV Multiaxial Diagnosis:

Axis I Dx Code \_\_\_\_\_

Axis II Dx Code \_\_\_\_\_

Axis III Current general medical condition potentially relevant to the understanding or management of the condition(s) noted in Axis I or II: Yes No

Axis IV Severity of current psychosocial stressors:

None mild moderate severe

Axis V GAF score: Highest pasts year at first session

Symptoms: (If applicable)

Self injurious behavior:	Mild	moderate	severe
Suicidal ideation:	mild	moderate	severe
Homicidal ideation:	mild	moderate	severe
Substance use problems:	mild	moderate	severe

Signature by clinician \_\_\_\_\_  
Inge 'Mula' Myllerup-Brookhuis Cand.Psych. M.A. LPC CEAP

# MENTAL STATUS EXAMINATION

## INTELLIGENCE:

- limited
- slow
- average
- bright

## ATTENTION TO TASK:

- distractible
- needs constant reinforcement
- persistent
- perseveration
- short attention span
- attentive

## ASSOCIATIONS:

- appropriate
- restricted
- circumstantial
- tangential
- loose
- flight of ideas
- clang
- rhyming
- punning
- impoverished

## PERCEPTIONS:

- illusions
- auditory hallucinations
- visual hallucinations
- tactile hallucinations
- olfactory hallucinations
- perceptual distortions
- reality based

## MEMORY IMPAIRMENT

- recent
- remote
- selective
- none apparent

## JUDGEMENT:

- objective
- subjective
- age appropriate

## INSIGHT:

- aware of problem(s)
- little insight
- other

## LOOK APPROXIMATELY:

- Stated Age
- Older
- Younger

## AFFECT:

- Appropriate
- Depressed
- Flat
- Anxious
- Inappropriate
- Elated
- Blunted
- Labile

## SLEEP IMPAIRMENT:

- difficulty falling asleep
- wakes during night
- wakes too early
- nightmares
- night terrors
- sleep walking
- enuresis
- encopresis
- other (explain)
- no impairment

## SUBSTANCE ABUSE:

- tobacco
- caffeine
- alcohol
- marijuana
- inhalants
- PCP
- Rx medications
- OTC drugs
- amphetamines
- barbiturates
- cocaine
- other (explain)
- none identified

## NEUROLOGICAL DIFFICULTY

- hop on one foot
- skip
- fingers - thumb
- alternate movement of hands
- associate movement
- right - left confusion
- eye tracking

- write own name
- over-active reflexes
- underactive reflexes
- toe walking
- alternating feet on stairs

## VISION:

- appears normal
- other

## HEARING:

- appears normal
- other

- Cooperative
- Guarded
- Hostile
- Suspicious
- Superficial
- Demanding
- Frightened
- Unresponsive

APPEARANCE:  
 Neat/well groomed  
 Disheveled  
 Casual  
 Bizarre

MOOD:  
 Worried  
 Sad  
 Despondent  
 Fearful  
 Happy  
 Withdrawn  
 Normal

SPEECH:  
 Average  
 Mute  
 Non-spontaneous  
 Pressured  
 Mumbled/Indistinct  
 Loud  
 Soft  
 Halting

BEHAVIOR:  
 Crying  
 Seductive  
 Tense  
 Aggressive  
 Threatening  
 Relaxed  
 Rigid  
 Agitated  
 Catatonic Stupor

ASSOCIATIONS:  
 Logical  
 Tangential  
 Circumstantial  
 Concrete  
 Flight of Ideas  
 Disorganized  
 Blocked  
 Racing  
 Preservative  
 Loose

THOUGHT CONTENT:  
 Sparse  
 Autistic  
 Depersonalization  
 Ideas of Unreality  
 Obsession  
 Phobias  
 Delusional  
 Hallucinations

ORIENTATION:  
 Intact:                       Time                       Person  
 Disoriented:               Place                       Situation

MEMORY IMPAIRMENT:  
 None  
 Mild  
 Moderate  
 Severe

IMMEDIATE RECALL:  
 Intact  
 Mild Loss  
 Moderate Loss  
 Severe Loss

INSIGHT \_\_\_\_\_ INTELLIGENCE \_\_\_\_\_ JUDGEMENT \_\_\_\_\_

ADDITIONAL COMMENTS:

APPETITE IMPAIRMENT

eat too much  
 recent weight loss  
 picky eater  
 food fads  
 anorexia nervosa  
 poor appetite  
 pica  
 binge eating  
 no impairment

Name: \_\_\_\_\_  
Signature of Observer \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

