Linda M. Sutton, MA LCPC
16335 So. Harlem Ave. Suite # 426 Tinley Park, IL 60477

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.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated

□ Divorced □ Widowed

Please list any children/age: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Permission to text May I text general information regarding appointments? □ Yes □ No

Cell/Other Phone: ( ) May we leave a message? □ Yes □ No

E-mail: _____ May I email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Free Monthly e Newsletter Subscriber (*Monthly Newsletters are emailed after therapy services have ended)*
___Yes ___No

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
__ No __Yes, previous therapist/practitioner: _____
Describe experience_____

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Are you currently taking any prescription medication?
□ Yes
□ No

Please list: _____

_____

Have you ever been prescribed psychiatric medication?
□ Yes
□ No

Please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION, *Month/Year of last physical*_____

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in _____

4. Please list any difficulties you experience with your appetite or eating patterns

_____

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5. Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
□ No
□ Yes

If yes, please describe _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

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

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

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ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation?

_____

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

_____

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

_____

_____

_____

4. What do you consider to be some of your weakness?

_____

_____

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

_____

INTAKE FORM **5.**

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(Please *provide information in specify detail)*

Presenting Problem (s):_____

_____

_____

_____

Why counseling at this time: _____

_____

_____

Major concern (s): _____

_____

_____

Anxious, Stressed, Depressed, etc. _____

_____

_____

Duration (How long?): _____

Impact on functioning: _____

_____

Previous efforts to Obtain help: _____

Currently Suicidal: Yes__ No___ If yes, describe your current plan _____

_____

Past Suicidal attempt___ Year of incident_____ Describe _____

_____

In Case of Mental Health Crisis/Suicide Call 988: Keep this number with you!

I received crisis number, *Please sign:* _____

Your Emergency contact for therapist: _____

Extended Family Problems: _____

INTAKE FORM 6.

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Client (s) _____Date_____

Have you ever been arrested and convicted of a felony: Yes___No____

Please Describe_____

_____

_____

Childhood/ Family

History: I was raised by…

(Check one) Bio Parent(s)_____Maternal Grandparent(s)___Close?____

Paternal Grandparent(s) ____Close?____other_____

I am the_____ of_____children.

Briefly describe your mom/dad and your relationship with them_____

_____

Positive Experiences/close relationship(s)_____

Negative Experience(s) _____

Any Traumatic life Experiences? *(Please* _____

explain)

_____

_____

Who can you call for support or emergency if needed?

Education:

High School/GED AA

Subject _____

BA___Subject_____

MA___Subject_____

How did you hear about my practice?

Psychology Today__GoodTherapy.org_____Internet_____Website____

Word of Mouth____Workshop____Other_____

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Client(s) _____Date_____

SPECIFIC PROBLEMS & GOALS COUNSELING

Problem 1: _____

_____

Goal 1: _____

_____

I would know that I have reached my goal when_ _____

_____

Problem 2: _____

_____

Goal 2:

I would know that I have reached my goal when_____

_____

Problem 3: _____

_____

Goal 3:

I would know that I have reached my goal when_____

_____

How motivated are you to work on these issues

Very Motivated____Somewhat____ Not as motivated as a should be____