Monica Michael LPC LLC

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Intake Form - Adult

Full Name:_____ Today's Date:_____

Age:_____ Birth Date:_____ Male or Female (Circle One)

Address:_____ City/State:_____

Zip:_____ Phone: _____ Email:_____

Occupation:_____ Emergency Contact Number:_____

Emergency Contact Name:_____ Relationship to You:_____

Marital Status (Circle One) Single Married Separated Divorced Widowed

Please check all applicable options and add comments as needed

I. Questions Regarding Overall Health:

Date of last physical:_____

Do you suffer from any of the following?

A. Sleep

___Difficulty Falling Asleep or Staying Asleep
___Difficulty Waking
___Restless Sleep
___Sleepwalking/Night terrors/Nightmares
___Bruxism (Grinding teeth)

B. Auditory/Olfactory

___Ringing in the Ears
___Hearing Loss
___Ear aches
___Decrease in Sense of Smell

C. Visual

___Double Vision
___Vision Problems/Blurred Vision
___Blind Spots

Clinician's Notes

Onset:

Duration:

Length:

Quality:

Dreams:

D. Other

___Allergies
___Asthma
___Frequent illness
___Fatigue
___Chronic pain

Clinician's Notes

E. Cardiovascular / Pulmonary

___Heart Problems ___Breathing Problems ___Palpitations or Tachycardia ___Hypertension

Clinician's Notes

F. Dermatological

___Skin Problems_____

_____

G. Endocrine

___Hot/ Cold Sensitivity
___Excessive Thirst
___PMS
___Diabetes
___Appetite Awareness
___Incontinence
___Sugar Sensitivity
___Thyroid Disorder
___Perimenopausal / Menopausal Symptoms

Clinician's Notes

H. Gastrointestinal

___Stomach Pain ___Chronic Constipation ___Irritable Bowel ___Nausea or Vomiting

Clinician's Notes

I. Neurological

___Headaches
___Coordination
___Weakness
___Motor or Vocal Tics
___Fainting
___Speech Problems
___Balance
___Seizures
___Tremor or Spasticity
___Accident Prone

Clinician's Notes

J. Orthopedic

___Chronic Pain/ Stiffness
___Chronic Aching Pain
___Low Pain Threshold
___High Pain Tolerance
___Chronic Nerve Pain (burning or stabbing)

Clinician's Notes

K. Habits (Please indicate both past and present participation)

___Caffeine Use ___Alcohol Use ___Cigarette Use ___Recreational Drug Use

Dietary Habits (Please characterize your general eating habits

_____

_____

L. Behavior/Emotions

___Mood Swings
___Panic Attacks
___Manic-Depression
___Anxiety
___Irritability
___Eating Disorders
___Depression
___Anger/Aggression
___Addictions
___Fears/Phobias
___Violent Behavior
___Risk-Taking Behavior
___Obsessive Compulsive Symptoms

Clinician's Notes

M. Academic and Cognitive

___Attention Span
___Sense of Direction
___Math
___Spatial Skills
___Art
___Distractibility
___Verbal Expression
___Writing
___Memory
___Impulsivity
___Reading
___ Problems with Homework
___Academic Strengths / Weaknesses
___Recurrent Complaints from Supervisors

N. Home Behavior

___Recurrent Problems with Neighbors
___Recurrent Problems with Relatives

Clinician's Notes

II. Personal History

A. Perinatal

___Prenatal Stress or Injury
___Difficult Birth
___Adopted at age ___
___Prenatal Drug Exposure
___Premature or Late Birth
___Difficult Labor
___Medical Problems after Birth

B. Growth and Development

___Colic
___Activity Level
___Motor Development
___Chronic Ear Infections
___Sleep Problems
___Attachment
___Allergies
___Asthma
___Eating Problems
___Emotional Development
___Language Development

C. Physical Traumas

___Head Injury
___Serious Illness
___Poisoning
___Accidents
___CNS Infection
___Anoxia
___Extreme Fever
___Overdose
___Stroke

D. Psychological Traumas and Stresses

___Abuse or Neglect ___Family Stress ___Death in Family ___Illness

E. Spiritual (Please be as specific as possible, estimating frequency of involvement)

___Prayer ___Fasting ___Meditation ___Bible/Wisdom Literature Reading ___Other

Denominational Affiliation:_____

Clinician's Notes

Treatment History

Medications: (Use backside if more room is needed)

Medication	For Condition	Dose	Dates

Medical Treatment:

Procedure	For Condition	Physician Address/Phone	Dates

Psychological Therapy:

Therapy	For Condition	Therapist Address/Phone	Dates

Other Therapy:

Therapist	For Condition	Therapist Address/Phone	Dates

Monica Michael, LPC
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Family History

Symptom	Yes	No	Relationship to You
Asthma			
Autoimmune Disorders: Type 1 Diabetes, Rheumatoid Arthritis, Lupus, MS, Scelorderma, etc.			
Migraine			
Sleep Problems			
Depression			
Manic-Depression			
Anxiety			
Phobias			
Panic Attacks			
Motor or Vocal Tics			
Eating Disorders or Obesity			
Addictions			
Obsessive Compulsive Symptoms			
Speech Problems			
Attention Problems			
Learning Problems			
Conduct Problems or Criminal			
Behavior			
Autism Spectrum			
Schizophrenia			