

Lynn C. Smythe, M.S, LMFT

Independent Practitioner Serving East. Snohomish and King Counties

14090 Fryelands Blvd. (suite 234) Monroe, WA 98272 and 15315 1st. Ave. NE, (suite 212) PO BOX 1021, Duvall, WA. 98019

(360)794-4830 ext. # 5 Secured Fax: (360)794-7252

New Client Intake Information

Your assistance in completing this questionnaire will be helpful in planning services for you as I work from a systems perspective. If there is any information you would prefer not to share, please let me know.

GENERAL INFORMATION

Full Name: _____ Today's Date: _____

Mailing Address: _____

Street or PO Box

Apt. #

_____ WA 98 - _____
City State Zip Code

Telephone: (_____) _____ OK to leave a message for you there? Yes No

Home

(_____) _____ OK to call you @ work? Yes No

Work

(_____) _____ OK to leave a message? Yes No

Cell Phone

Emergency contact: _____ Phone # _____

Your age: _____ DOB: _____ Social Security Number: _____

Driver's License #: _____

PERSON RESPONSIBLE FOR BILL, IF NOT CLIENT

Name: _____ Relationship: _____

Address: Same as client

(If different from client's) Street address or PO Box _____

City _____ State _____ Zip Code _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell: (_____) _____

Insurance Information:

Primary Insurance _____

Secondary Insurance: _____

Phone #: _____

Phone #: _____

Contract #: _____

Contract #: _____

Group #: _____

Group #: _____

Subscriber: _____

Subscriber: _____

Subscriber date of birth: _____

Subscriber date of birth: _____

Patient's relationship to subscriber: _____

Patient relationship to subscriber: _____

Education: 9 10 11 HSGrad 13 14 AA BA MA Ph.D.

Circle highest year/degree completed

Occupation: _____ Years in this occupation? _____

Place of Employment: _____ Yrs Employed Here? _____

Previous Employment: _____

How were you referred for my services? _____

May I thank them? (please initial) ___ Yes ___ No

Please describe your reason(s) for seeking help today:

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Coping skills | <input type="checkbox"/> Depression | <input type="checkbox"/> Relationships |
| <input type="checkbox"/> +/-Sleep | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Fear/Phobias | <input type="checkbox"/> Mental Confusion | <input type="checkbox"/> Sexual |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Drugs | <input type="checkbox"/> Addiction | <input type="checkbox"/> Energy level | <input type="checkbox"/> Stress/tension |
| <input type="checkbox"/> Weight | <input type="checkbox"/> Aggression | <input type="checkbox"/> Antisocial | <input type="checkbox"/> Avoiding people | <input type="checkbox"/> Cyber addiction |
| <input type="checkbox"/> Distracted | <input type="checkbox"/> Elevated mood | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Gambling |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Worry | <input type="checkbox"/> Heart racing | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Impulsivity |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Judgment errors | <input type="checkbox"/> Grief | <input type="checkbox"/> Chest pains | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Obsessive thoughts / rituals | <input type="checkbox"/> PTSD | <input type="checkbox"/> Withdrawing | <input type="checkbox"/> Memory lapses | <input type="checkbox"/> Sexual addiction |
| <input type="checkbox"/> Mood shifts | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Hearing voices | <input type="checkbox"/> Family issues | <input type="checkbox"/> Sadness/Tearful |
| <input type="checkbox"/> Court order | <input type="checkbox"/> Sick often | <input type="checkbox"/> Disorganized | <input type="checkbox"/> Scary thoughts | |

Are you having any suicidal or homicidal thoughts? No Yes In the past ___ Yes ___ No

Briefly describe how the above symptoms impair your ability to function effectively:

Have you or a family member had prior counseling? No If yes, please complete the following:

- Therapist's Name(s) and/or Agency: _____
- Approximate Date(s) and length of services: _____
- Persons Involved: _____
- Issues Addressed: _____
- This experience was: very helpful somewhat helpful not helpful made things worse

Have you had any hospitalizations? ___ Yes ___ No

If yes describe: _____

Have you had any drug/alcohol treatment? ___ Yes ___ No

If yes describe: _____

Have you been involved in any self-help groups? ___ Yes ___ No

What was your reaction to the overall experience? _____

MEDICAL INFORMATION

Primary Physician: _____ Last seen? _____ Telephone (____) _____
 Address: _____

Current health problems for which you are receiving treatment: None

List any medications you are currently taking: (This information is mandatory if you are using insurance)

<u>Medication</u>	<u>Dosage</u>	<u>Reason Taken</u>	<u>Date started</u>	<u>Prescribing Provider</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

*Use back of page if more room is needed

Indicate current use pattern:

- Nicotine None Occasional Frequent Abuse Addicted Quit in _____
Year
- Caffeine None Occasional Frequent Abuse Addicted Quit in _____
Year
- Alcohol None Occasional Frequent Abuse Addicted In rec. since _____
Year
- Non Rx Drugs None Occasional Frequent Abuse Addicted In rec. since _____
Year
- Prescription Drugs None Occasional Frequent Abuse Addicted

Substance(s) of preference: _____

Describe when and where you typically use substances: _____

Describe how your use has affected your family or friends (including their perceptions of your use): _____

Reasons for use: __ Addicted __ Socialization __ Build confidence __ Taste __ Escape
 __ Self medication __ Other: _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Does someone in your family present/past have/had a problem with drugs or alcohol? __ Yes __ No
 If yes, describe: _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? __ Yes __ No
 Have you had adverse reactions or overdose to drugs or alcohol? __ Yes __ No
 If yes describe: _____

Have drugs or alcohol caused a problem for your job/school? Yes No

If yes describe: _____

Childhood Development

Are there special, unusual, or traumatic circumstances that affected your development? Yes No

If yes please describe: _____

Has there been history of child abuse? Yes No

If yes, which type? Sexual Physical Verbal Emotional

If yes, the abuse was as a Victim Perpetrator Both

Social Relationships

How do you generally get along with other people: (check all that apply)

Affectionate Aggressive Avoidant Fight/argue often Follower Friendly

Leader Outgoing Shy Withdrawn Submissive Ambivalent

Other: _____

Sexual orientation: _____ Comments: _____

Sexual dysfunctions Yes No If yes describe: _____

Social groups/supports: _____

Leisure/Recreational

Describe special areas of interest or hobbies (art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activities: _____

How often now? _____

How often in the past? _____

Cultural

To which cultural or ethnic group, if any, so you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? _____

Other cultural information _____

Spiritual

How important to you are spiritual matters? Not Little Moderate Much

Are you affiliated with a spiritual or religious group? Yes No

If yes describe: _____

Would you like your spiritual/religious beliefs incorporated into the counseling? Yes No

Legal

Are you involved in any cases (traffic, civil, criminal)? Yes No

If yes, please describe: _____

Are you presently on probation or parole? Yes No

If yes please describe: _____

Have you had past violations: Yes No

Traffic violations DWI, DUI, etc.: Criminal involvement Civil involvement Other

If you responded yes to any of the above, please fill in the following information:

Charges: _____

Date(s): _____

Where (city/state): _____

Results: _____

Military

Military experience? Yes No

Where: _____

Branch: _____

Date drafted: _____ Date enlisted: _____ Discharge date: _____ Type of discharge: _____

Rank at discharge: _____

Any other information you want me to know? _____

FAMILY INFORMATION

Partner (if applicable): _____ Years together _____

Address: Same _____
(If different from client's)

Age: _____ DOB: _____

Relationship Status: Single Living Together Married Life Partners
 Informally Separated Legally Separated Divorced Other _____

<u>Parents:</u>	<u>Name</u>	<u>Age</u>	<u>Describe w/3 adjectives</u>
Father	_____	_____	_____
Step F.	_____	_____	_____
Mother	_____	_____	_____
Step M.	_____	_____	_____

Siblings

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Children

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

* continue on the back of this form if more room is needed

Any additional information that would assist me in understanding you concerns or problems?

What are your goals for therapy?

For staff use

Therapist's signature/credentials: _____ Date: _____

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Physical exam : _____required _____ Not required

Therapist comments:
