

# Stefanie Von Ohlen, LCSW

## Intake Form / Background Information

Full Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Telephone \_\_\_\_\_ OK to contact you at home? \_\_\_\_\_ OK to leave a message? \_\_\_\_\_

Mobile Telephone \_\_\_\_\_ OK to text appointment info/confirmation? \_\_\_\_\_

Email \_\_\_\_\_

How did you hear about Stefanie Von Ohlen, LCSW? \_\_\_\_\_

### REASON FOR SEEKING TREATMENT

Please briefly describe the problem you are experiencing.

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What do you hope to be able to do or achieve as a result of treatment?

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Do you currently have thoughts of harming yourself?  Yes  No

Have you in the past?  Yes  No If Yes, how long ago? \_\_\_\_\_

Do you currently have thoughts of wishing you were dead?  Yes  No

Do you currently have urges to hurt, harm, or kill someone else?  Yes  No If Yes, whom? \_\_\_\_\_

Have you ever seriously considered suicide or felt like harming someone else?  Yes  No

If Yes, please explain \_\_\_\_\_

Name of Current Psychiatrist (and phone #) \_\_\_\_\_

Have you ever had previous therapy/counseling of any kind?  Yes  No

If Yes, when, with whom, and for how long? \_\_\_\_\_

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Have you ever been hospitalized for emotional problems? Yes No

Have you ever been hospitalized for substance abuse problems? Yes No

If Yes to either of the above, please note when, where, and for how long you were hospitalized

\_\_\_\_\_  
\_\_\_\_\_

### SUBSTANCE USE HISTORY

Have you ever experienced a problem with alcohol, drugs, or prescription medications? Yes No

If Yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Have you ever been treated for problems with alcohol, drugs, or abuse of prescription medications? Yes No

If Yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Have you had any problems related to use of alcohol/drugs in the past year? Yes No

If Yes, please explain: \_\_\_\_\_

\_\_\_\_\_

### FAMILY BACKGROUND

Please check this box if you have no children:

Names of Children	Living with you?	Age	Grade	School
1. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
2. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
3. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____

Please describe your relationships with other family members:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Check the statement(s) below that describe the type of family you grew up in:

- overly close family      no "breathing room"      everyone was in everyone else's business      no privacy
- boundaries not respected      comfortably close family      loving shared many positive experiences      supportive
- distant, everyone did their own thing      not much time spent together      not a lot of support      angry, lot of fighting/hostility

verbal abuse and conflicts    violence    frightening    scared to make mistakes

Have any biological relatives ever had any emotional problems or substance abuse? Yes No

If Yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Has anyone in your family ever attempted or committed suicide? Yes No

If Yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

## MARITAL/RELATIONSHIP STATUS

Married    Live with partner    Single  
Separated/Divorced    Widowed    Other: \_\_\_\_\_

Comments regarding stresses in current or previous marriage(s)/relationship(s)  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been abused mentally or physically by a romantic partner? Yes No

Does this apply to your current relationship? Yes No

Do you feel safe? Yes No

## EMPLOYMENT/EDUCATION INFORMATION

Check all that apply:    employed    retired    disabled  
student    homemaker    unemployed

If/When employed, what type of work do you do? \_\_\_\_\_  
\_\_\_\_\_

Current employer is: \_\_\_\_\_ Years on current job: \_\_\_\_\_

Your income: \_\_\_\_\_ Total household income: \_\_\_\_\_

Highest degree completed in school: \_\_\_\_\_

## HEALTH/MEDICAL INFORMATION

Please list significant medical problems/conditions, now or in the past, and indicate if you are receiving treatment for them:

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Do any of these problems affect your everyday life?  Yes  No

If Yes, how so? \_\_\_\_\_  
\_\_\_\_\_

Have you ever blacked out and/or lost consciousness and/or experienced any type of serious head injury or trauma?  Yes  
 No

If Yes, please indicate when and what happened \_\_\_\_\_  
\_\_\_\_\_

List all medication you currently use:

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Dosage (amount and times per day) \_\_\_\_\_

Reason(s) \_\_\_\_\_

Name of Primary Care Physician (PCP) \_\_\_\_\_

## IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone # (Daytime) \_\_\_\_\_

Telephone # (Evening) \_\_\_\_\_

Telephone # (Cell) \_\_\_\_\_