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.

_____

_____

_____

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

_____

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?_____

_____

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._____	☐Yes ☐No	____	_____	_____
2._____	☐Yes ☐No	____	_____	_____
3._____	☐Yes ☐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:

_____

_____

_____

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:

_____

_____

_____

_____

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)_____