LYNNE MOSER, LCSW

LICENSED CLINICAL SOCIAL WORKER

917.605.1006

CLIENT INTAKE & HISTORY

Welcome to *Lynne Moser, LCSW, LLC* and thank you for choosing me as your provider. In order to best serve you, please complete this packet before your initial visit.

IDENTIFICATION

Name: _____ Date of Birth: _____ Age: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: Home: _____ OK to leave message? Yes / No
Cell: _____ OK to leave message? Yes / No
E-mail: _____ Marital Status: _____

Employer: _____ **Occupation:** _____
Highest Level of Education: _____
Name of School (if applicable): _____ Grade: _____

EMERGENCY CONTACT

In the event that you experience an emergency and cannot be reached, please provide an individual with whom your therapist can notify or verify your safety.

Name: _____ OK to ID as Lynne Moser? Yes / No
Relationship: _____ Phone: _____

REFERRAL SOURCE

How or from whom did you learn about my practice?

_____

PRESENTING CONCERN(S)

What brings you to therapy at this time? *Include onset, duration and intensity of symptoms. What was the precipitating event and what do you hope to achieve?*

_____
_____
_____
_____
_____
_____

MEDICAL HISTORY

Primary Care Physician Name and Phone #: _____
Date of Last Physical: _____
Exam Findings: _____
Allergies: _____

May I inform your doctor that we are working together in therapy so that he/she and I can coordinate your care? ____ Yes ____ No

Medical or psychiatric condition(s) and treatment:

_____

Current medications, dosage, and name of prescribing physician:

_____
_____
_____

Hospitalizations/surgeries:

_____
_____
_____

Past psychiatric treatment (mental health/chemical dependency):

_____
_____
_____

How would you describe your mental health at this time (circle one)?

Poor Fair Good Very Good Excellent

Have you ever purposely injured or cut yourself? Yes __ No __ If yes, please explain:

_____
_____

Have you ever had suicidal thoughts, plans or attempts? Yes ___ No ___ If yes, please explain:

_____
_____

Prior outpatient therapy (previous therapists, dates of treatment, response to interventions):

_____
_____
_____

SUBSTANCE USE HISTORY:

Substance	Amount	Frequency	Age First Use	Age Last Use
Caffeine				
Nicotine				
Alcohol				
Marijuana				
Opioids/Narc				
Amphetamines				
Cocaine				
Hallucinogens				
Other				

Have you ever experienced alcohol or drug-induced blackouts? Yes __ No __

Has anyone ever expressed concern about your alcohol and/or drug use? Yes __ No __

Have you ever been arrested or convicted for DUI? Yes __ No __

Have you ever sold or manufactured drugs? Yes __ No __

Have you ever attended AA/NA or drug/alcohol rehab for substance abuse? Yes __ No __

PSYCHOSOCIAL INFORMATION:

Identified Support Systems

_____

_____

School/Work Life notes

_____

_____

Marital History

_____

_____

Legal History

Military History

Spiritual/Religious Beliefs

FAMILY & SIGNIFICANT OTHERS

Have there been any significant changes or upsets in the family? Explain.

How do family members get along? Explain.

Family Members	DOB	Age	Years of Education or Highest Degree	Occupation	Lives at home?
Spouse/Partner					
Son/Daughter					
Son/Daughter					
Son/Daughter					
Sibling					
Sibling					
Sibling					
Parent					
Other					

Are there any family members with a history of the following conditions?

	Depression	Anxiety	Substance Abuse/ Addiction	Bipolar Disorder	Schizo-phrenia	Trauma	Other
Parent							
Sibling							
Child							
Aunt/Uncle							
Grandparent							

OTHER RELEVANT INFORMATION:

Please provide any additional information that you think may be relevant to our work together.

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

For Children & Teens Only

Developmental History Concerns: _____
_____

Perinatal History (details regarding labor/delivery):_____
_____

Prenatal History (medical problems during pregnancy): _____
_____