Julie Trosin, LMFT, LMFT78612
www.julietrosinmft.com
(408) 718-7405

ADULT INTAKE INFORMATION

NOTE: Please do NOT complete or send this form unless you have had a free phone consultation with Julie Trosin, LMFT confirming mutually to proceed and schedule an initial intake assessment appointment.

Date: _____ How or by whom were you referred? _____
Availability: Days of Week_____ Times_____

Client Information

Full Name_____ Ethnicity_____ Age____DOB_____Sex: M / F
Address_____City_____State____Zip_____
Home Phone_____Cell Phone_____Work Phone_____
Okay to leave voice messages? Y/ N Okay to Text? Y/N Email:_____
Current Occupation _____ Employer_____

In Case of Emergency

In the event that a therapist has reasonable concerns regarding safety (risk factors, danger to self or others) during the course of treatment and is unable to reach you (the client), an emergency contact(s) ("safety support person") is someone whom would be contacted. If unable to reach your emergency contact(s) and/or confirm you are safe, non-emergency police may be called to do a Safety & Wellness check.

Notify_____ Phone _____Relationship _____

Alternative_____ Phone _____Relationship _____
(If first emergency contact cannot be reached)

Physician/Clinic _____Hospital _____Phone _____
Medical/Health Insurance (if applicable)_____
Psychiatrist (if applicable) _____ Phone _____

Financial Responsibility Information (Guarantor, if different from listed client)

Name_____ Relationship to Client _____
Address_____City_____State_____Zip_____
Home Phone_____ Cell Phone _____Work Phone _____
Place of Employment_____ How long?_____

Guarantor Agreement: I certify that the above information is true and correct. I agree to take full responsibility for the entire balance due for any and all services rendered by Julie Trosin, LMFT to client listed above, in accordance with the completed Informed Consent. This includes full payment of any 24hr late-cancellation fees.

Guarantor Signature (if different from listed client): _____ Date _____

Signature _____ Date_____

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What made you decide to seek help at this time? Please briefly describe what specific goals and issues/areas of your life you are wanting help with: _____

_____

_____

_____

How long and how often have you had these problems or symptoms? _____
What have you tried to address these problems/symptoms? What has been helpful? _____

_____

_____

What are you wanting to achieve as a result of our work together? What would it look like (or what would be different) if therapy was "successful'? _____

_____

_____

_____

Social History

Marital Status: Single _____ Dating _____ Engaged_____ Married _____years
Dated how long before current marriage? _____ Cohabitating _____ years
Widowed _____years Divorced_____years Separated_____years
Married_____times (including current marriage, if applicable) Partner/Spouse married ____times
If married/dating, how would you describe the current quality of your marriage/relationship?

_____

_____

Children: Please indicate How Many, Names, Gender, and Ages.
Biological? _____ Step? _____ Adopted? _____ Living at home? _____

_____

Of the following, please indicate how many and when they occurred.
Deaths?_____ Miscarriages? _____ Stillborns? _____ Abortions?_____
Siblings: Please indicate Gender and Ages. Biological?_____
Step?_____ Half?_____ Adopted?_____
Parents: Living or Deceased? And if deceased, how old were *you* at the time of their death?
Mother _____ Father _____
Please describe your relationship with your *mother* (primary female caregiver) growing up:

_____

Currently: _____
Please describe your relationship with your *father* (primary male caregiver) growing up:

_____

Currently: _____
Please describe your relationship(s) with your sibling(s), if applicable, growing up:

_____

Currently: _____

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Support System: Please list any friends, family members, and/or organizations that are important to you; to whom, and where you can turn to for emotional, social or spiritual support.

_____

_____

Spiritual: Describe the role of religion or spirituality in your life. _____

_____

Medical History

Physical: Do you have any physical or health problems at this time? Yes or No
If yes, please explain. _____

_____

Have you ever experienced a concussion, lost consciousness or serious head injury? Yes or No
If yes, please describe what happened and when the injury occurred _____

_____

List any major surgeries_____

_____

Alcohol/Drug Use: How often do you drink alcohol? ____ times per week ____ times per month
What (beer, wine, hard liquor) do you drink and how much? _____
Do you feel you may have a problem with alcohol? (ie. causes problems with your family, relationships, job, health, productivity, difficult to stop, etc) _____Other drugs?_____
Age you first started drinking? _____Using drugs?_____
Have drugs or alcohol ever been a problem in your life? Y___ N____ If yes, when?_____

Check any/all that apply within the last 6 months:
____ Blacking/passing out and/or not remembering what happened (when intoxicated)
____ Continuing to drink despite natural consequences (physically, emotionally, relationally, legally)
____ Friends, family, partner, and/or work expressing comments/concerns about your drinking
____ Using alcohol to numb/avoid feelings and/or feel more "comfortable" socially
____ *You* having concerns about your drinking (amount, frequency, consequences, etc.)

Do you use any non-prescription drugs (ie. marijuana, cocaine, meth, etc.)? Which? Frequency?

_____

Do you or any family members have a history of alcohol/chemical dependency? Yes or No
If yes, who and please describe_____

_____

Are you currently taking any prescription medication? Yes or No

1. _____ Dosage/Frequency _____ Start Date _____
Purpose: _____ Who prescribed? _____
2. _____ Dosage/Frequency _____ Start Date _____
Purpose: _____ Who prescribed? _____
3. _____ Dosage/Frequency _____ Start Date _____

Purpose: _____ Who prescribed? _____

4. _____ Dosage/Frequency _____ Start Date _____

Purpose: _____ Who prescribed? _____

Do you feel that the medication(s) has been helpful?

Clinical Information: Please list any previous counseling, treating therapist's name and/or psychiatric hospitalizations, what treatment was for, and approximate dates:

_____

_____

_____

If applicable, did you feel it was helpful? What did you like or dislike about the experience? Why was counseling stopped?

_____

_____

Have you previously been given (or suspect) any clinical diagnosis? If so, what, when and by whom?

_____

Do you have any previous psychiatric hospitalization(s)? Yes or No

Have any family members struggled with (even if not formally diagnosed) with a mental illness (ie. depression, anxiety, OCD, PTSD, bipolar, borderline personality, ADHD, schizophrenia, etc. and/or been hospitalized at a psychiatric facility? Yes or No
If yes, who? What mental illness? What facility? For how long, and when? _____

_____

Have you ever attempted suicide? Yes or No
If yes, when and how? _____

Do you have *thoughts* of suicide or hurting yourself right now? Yes or No
If yes, do you have a plan/urge/intention to do so or concerns you may do so? Yes or No

Do you have *thoughts* of violence/hurting someone else? Yes or No
If yes, do you have concerns that you may act on those thoughts? Yes or No
Do you have a history of rage and/or aggression/violence? Yes or No

Have you ever experienced or witnessed domestic violence? Yes or No
If yes, growing up, as an adult or both? _____

Have you ever experienced any type of physical/psychological abuse or neglect? Yes or No

Have you ever experienced sexual abuse/molest/incest/rape? Yes or No

Have you ever experienced an eating disorder? Yes or No

Have you ever experienced traumatic loss? (loss of relationship/job/property, divorce, traumatic betrayal, suicide/homicide of loved one, etc) Yes or No

Are you currently involved in a lawsuit or thinking of suing anyone? Yes or No
If yes, or any other legal involvements (such as custody battle, divorce, injury, etc.) I should know about, please explain: _____

_____

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Mental Status

Please check any/all of the following that describe how you have been feeling lately:

___ depressed	___ confused	___ distracted	___ angry/resentful	___ frightened
___ irritable	___ worthless	___ lonely/isolated	___ sad/tearful	___ overwhelmed
___ hopeless	___ aggressive	___ hyper/restless	___ numb/detached	___ extreme ups/downs
___ anxious	___ triggered	___ ruminating	___ impulsive	___ paranoid

THE AMEN CLINIC QUESTIONNAIRE

0 = Never 1 = Rarely 2 = Occasionally 3 = Frequently 4 = Very Frequently

_____ 1. Frequent feelings of nervousness or anxiety
_____ 2. Panic attacks
_____ 3. Avoidance of places due to fear of having an anxiety attack
_____ 4. Symptoms of heightened muscle tension (sore muscles, headaches)
_____ 5. Periods of heart pounding, nausea, or dizziness (not due to exercise)
_____ 6. Tendency to predict the worst
_____ 7. Multiple, persistent fears or phobias (ie. dying, doing something crazy)
_____ 8. Conflict Avoidance
_____ 9. Excessive fear of being judged or scrutinized by others
_____ 10. Easily startled or tendency to freeze in intense situations
_____ 11. Seemingly shy, timid, and easily embarrassed
_____ 12. Bites fingernails or picks skin
_____ Total number of questions with a score of 3 or 4 for questions 1- 12.

_____ 13. Persistent sad or empty mood
_____ 14. Loss of interest or pleasure from activities that are normally fun
_____ 15. Restlessness, irritability, or excessive crying
_____ 16. Feelings of guilt, worthlessness, helplessness, hopelessness
_____ 17. Sleeping too much or too little, or early morning waking
_____ 18. Appetite changes/ weight loss or weight gain through overeating
_____ 19. Decreased energy, fatigue, feeling “slowed down”
_____ 20. Thoughts of death or suicide, or suicide attempts
_____ 21. Difficulty concentrating, remembering, making decisions
_____ 22. Physical symptoms; headaches, chronic pain, digestive problems
_____ 23. Persistent negativity or low self esteem
_____ 24. Persistent feeling of dissatisfaction or boredom
_____ Total number of questions with a score of 3 or 4 for questions 13-24.

_____ 25. Excessive or senseless worrying
_____ 26. Upset when things are out of place or don’t go according to plan
_____ 27. Tendency to be oppositional or argumentative
_____ 28. Tendency to have repetitive negative or anxious thoughts
_____ 29. Tendency toward compulsive behaviors
_____ 30. Intense dislike of change

____ 31. Tendency to hold grudges
____ 32. Difficulty seeing options in situations
____ 33. Tendency to hold on to own opinion and not listen to others
____ 34. Needing to have things done a certain way or you become upset
____ 35. Others complain you worry too much
____ 36. Tendency to say no without first thinking about the question
_____ Total number of questions with a score of 3 or 4 for questions 25-36.

____ 37. Periods of abnormally happy, depressed or anxious mood
____ 38. Periods of decreased need for sleep, energetic on much less sleep
____ 39. Periods of grandiose thoughts and ideas (feeling very powerful)
____ 40. Periods of increased talking or pressured speech
____ 41. Periods of too many thoughts racing through your mind
____ 42. Periods of increased energy level
____ 43. Periods of poor judgment that leads to risk-taking behaviors
____ 44. Periods of inappropriate social behavior
____ 45. Periods of irritability or aggression
____ 46. Periods of delusional or psychotic thinking
_____Total number of questions with a score of 3 or 4 for questions 37 – 46.

____ 47. Short fuse or periods of extreme irritability
____ 48. Periods of rage without being provoked
____ 49. Often misinterprets comments as negative when they are not
____ 50. Periods of spaciness or confusion
____ 51. Periods of panic or fear for no specific reason
____ 52. Visual or auditory changes (seeing shadows or hearing sounds)
____ 53. Frequent periods of déjà vu (feeling you've been somewhere you have never been)
____ 54. Sensitivity or mild paranoia
____ 55. Headaches or abdominal pain of uncertain origin
____ 56. History of head injury or family history of violence/ explosiveness
____ 57. Dark thoughts, may be homicidal or suicidal
____ 58. Periods of forgetfulness or memory problems
_____ Total number of questions with a score of 3 or 4 for questions 47- 58.

____ 59. Trouble staying focused
____ 60. Spaciness or feeling like you're in a fog
____ 61. Overwhelmed by tasks of daily living
____ 62. Feels tired, sluggish, or slow moving
____ 63. Procrastination, failure to finish things
____ 64. Chronic boredom
____ 65. Loses things
____ 66. Easily distracted
____ 67. Forgetful
____ 68. Poor planning skills
____ 69. Difficulty expressing feelings
____ 70. Difficulty expressing empathy for others
_____ Total number of questions with a score of 3 or 4 for questions 59-70.

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Describe any other feelings or symptoms (emotionally, mentally, physically, socially, spiritually, etc.) you have been having recently. _____

_____

_____

What current hobbies or activities do you participate in? _____

_____

_____

Do you participate in regular exercise? Describe. _____

_____

Describe your current work and/or school environment. _____

_____

Have you had any recent concerns about or changes in your sleeping habits? Yes or No
Describe: _____

____ Nightmares/Night terrors ____ Insomnia/Trouble falling and/or staying asleep

Have you had any recent concerns about or changes in your eating habits? Yes or No
Describe: _____

____ Anorexia (past or present) ____ Bulimia (past or present) ____ Emotional Eating

What gives you the most pleasure or joy in your life currently?

_____

_____

What are your main concerns, worries or fears currently?

_____

_____

What do you consider your current strengths or healthier coping mechanisms that you are using?

_____

_____

Is there anything else that you feel would be important for me to know that would help my understanding of your situation?

_____

_____

_____

_____

_____

_____

****

*** ***THANK YOU FOR TAKING THE TIME AND EFFORT TO FILL OUT THIS FORM.*** ***