Lara Neely, DBH, MED, LPC

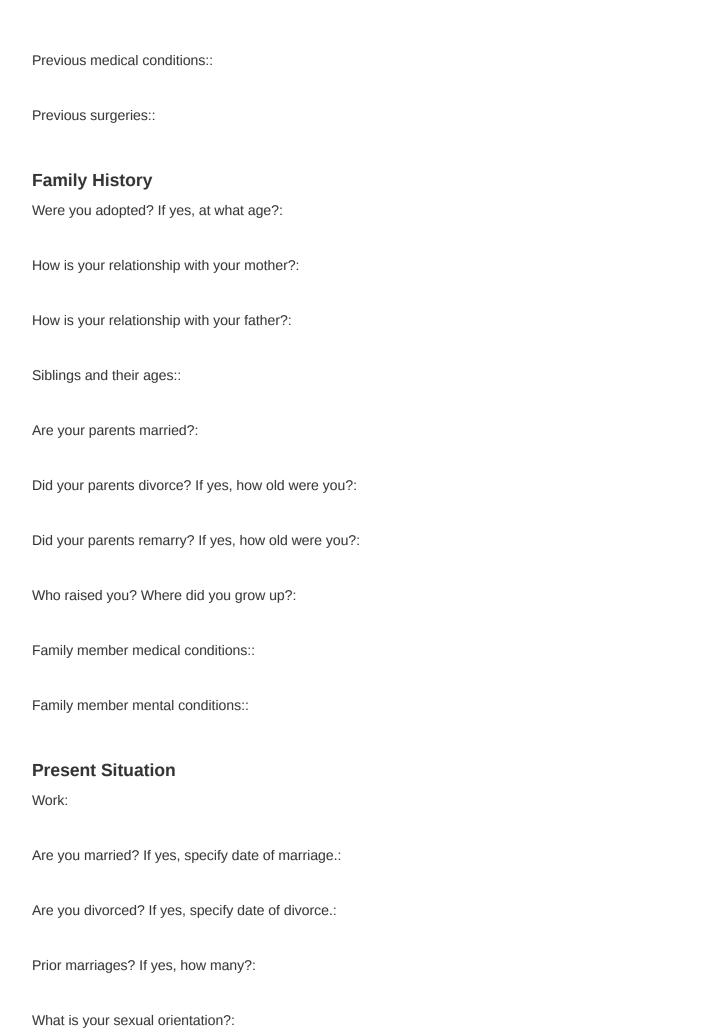
STANDARD INTAKE QUESTIONNAIRE

Are you currently under the care of any practitioner for mental health purposes (ex: Nurse Practitioner prescribes anxiety medication, Primary Care Physician is working with you to stop smoking, Marriage Counselor is working with you and your spouse)? If so, what is their name and number and when was the date of your last appointment?:

appointment?: **Complaint** What is your major complaint or reason for seeking therapy with Lara Neely, DBH, MED, LPC?: Have you previously suffered from this complaint?: If Yes, enter previous therapist(s) seen for complaint, describe treatment.: Aggravating Factors- What makes your situation worse?: Relieving Factors- What helps your situation?: **Current Symptoms** (check all that apply) Anxiety Appetite Issues Avoidance Crying Spells Depression Excessive Energy

Fatigue

☐ Guilt
☐ Hallucinations
☐ Impulsivity
☐ Irritability
☐ Libido Changes
☐ Loss of Interest
☐ Panic Attacks
☐ Racing Thoughts
☐ Risky Activity
☐ Sleep Changes
Suspiciousness
Medical History
Are you currently under the care of a practitioner for any chronic health issues (ex: Diabetes, Weight Loss, Sleep Disorders, etc.)? If so, explain why and give the provider's name and date of last appointment.:
How long ago was your last blood workup?:
Exercise Frequency::
Exercise Type::
List allergies::
What medications are you currently using?:
Previous diagnoses/mental health treatment::
Previously treated by::
Previous medications::
Dates treated:



Are you sexually active?:
How is your relationship with your partner?:
Do you have child(ren)? If yes, how is your relationship with your child(ren)?:
Are you a member of a religion/spiritual group?:
Have you ever been arrested? If yes, when and why?:
Have you ever tried the following?
(check all that apply)
Alcohol
Tobacco
☐ Marijuanna
☐ Hallucinogens (LSD)
Heroin
Methamphetamines
Cocaine
Stimulants (Pills)
Ecstasy
Methadone
Tranquilizers
☐ Pain Killers
If yes to any, list frequency/dates of use:
Have you ever been treated for drug/alcohol abuse? If yes, when?:

Do you smoke cigarettes? If yes, how many per day?:

Do you drink caffeinated beverages? If yes, how many per day?:

Have you ever abused prescription drugs? If yes, which ones?:

Additional

Is there anything else you want the therapist to know?: