

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?:

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:

Previous medical conditions::

Previous surgeries::

Family History

Were you adopted? If yes, at what age?:

How is your relationship with your mother?:

How is your relationship with your father?:

Siblings and their ages::

Are your parents married?:

Did your parents divorce? If yes, how old were you?:

Did your parents remarry? If yes, how old were you?:

Who raised you? Where did you grow up?:

Family member medical conditions::

Family member mental conditions::

Present Situation

Work:

Are you married? If yes, specify date of marriage.:

Are you divorced? If yes, specify date of divorce.:

Prior marriages? If yes, how many?:

What is your sexual orientation?:

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
- Marijuana
- 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?: