Life Point Counseling, LLC
.....finding hope at every point in life

INTAKE INFORMATION

All information provided in this application is considered part of the patient file and is, therefore, confidential. The information you provide is helpful in determining what services are most beneficial to you. Please fill out all parts.

CLIENT'S FULL NAME	AGE	DATE OF BIRTH	☐MALE ☐FEMALE ☐OTHER_____

PURPOSE FOR TREATMENT

Why are you seeking services at this time? (Describe concerns, worries, etc.)

How long have these problems been present?

On a scale of 1 (low) to 10 (high), how would you rate the impact of these problems in your life?

1 2 3 4 5 6 7 8 9 10

LIVING ARRANGEMENT

Please describe who you are living with: (Name, relationship, etc.)

☐ with Family ☐ Life Partner ☐ Group Home ☐ Foster Home ☐ Nursing Home ☐ Intistute ☐ Alone ☐ Shelter
☐ with Spouse ☐ with Relative ☐ Non-Relative ☐ Half-way home ☐ Correctional ☐ Other:_____

MARITAL & FAMILY HISTORY

❑ Single ☐ In Relationship ☐ Married ☐ Engaged ☐ Widowed ☐ Separated ☐ Remarried ☐ Divorced ☐ Other_____

NAME OF PRESENT PARTNER:	OCCUPATION:	AGE:	DATE OF BIRTH:
YEARS IN CURRENT MARRIAGE/RELATIONSHIP:	TOTAL YEARS IN OTHER MARRIAGES/RELATIONSHIPS:		

FAMILY

	Name:	Date of Birth:	Age:
Mother:			
Father:			
Step-Mother:			
Step-Father:			
Siblings:			
Children:			

Do/have any other family members have (had) any psychiatric or alcohol/drug problems or treatment? ☐Yes ☐No

EDUCATIONAL HISTORY

Highest grade completed: *Primary:* 1 2 3 4 5 6 7 8 *High School:* 9 10 11 12 *College:* 13 14 15 16 *Post Graduate:* 17 18 19 +

Degrees received & graduation dates:

Presently attending school? ☐**Yes** ☐**No** If yes, where?

Retained in any grades? ☐**Yes** ☐**No** If yes, what grades?

Skipped any grades? ☐**Yes** ☐**No** If yes, what grades?

Have you ever been expelled? ☐**Yes** ☐**No** If yes, why?

Have you ever been suspended? ☐**Yes** ☐**No** If yes, why?

Have you participated in special education? Please specify: ☐***N/A*** ☐***Emotional Disorders*** ☐***Learning Disability*** ☐ ***Cognitive Deficits***

Did/do you have (had) any school concerns?

CHILDHOOD HISTORY

Where were you born?

Where did you grow up?

CHILDHOOD PRESENTING PROBLEMS

☐ NONE APPLY	☐ Resentful	☐ Identity issues	☐ Running away	☐ Angry	☐ Hyperactive	☐ Immature	☐ Fidgety
☐ Sexual issues	☐ Premature	☐ Drug abuse	☐ Anorexia	☐ Shy	☐ Inattention	☐ Sensory issues	☐ Distracted
☐ Attachment	☐ Arguing	☐ Bedwetting	☐ Animal abuse	☐ Anxiety	☐ Stealing	☐ Tantrums	☐ Impulsive
☐ Encopresis	☐ Lying	☐ Nightmares	☐ Eating issues	☐ Fears	☐ Fire setting	☐ Fighting	☐ Sneaky
☐ Manipulative	☐ Hairpulling	☐ Failing grades	☐ Truancy	☐ Defiant	☐ Tantrums	☐ School issues	☐ OTHERS:

SUBSTANCE USE HISTORY

☐ **SUBSTANCE USE NOT APPLICABLE TO CLIENT**

CAGE

Cutting Back	Have you ever cut down or tried to cut down on your alcohol or drug use (or gambling, etc)?	☐Yes	☐No
Annoyance	Do you ever feel annoyed when others complain about your drinking or drug use (your gambling, etc.)?	☐Yes	☐No
Guilt	Do you ever feel bad or guilty about your use of alcohol or drugs?	☐Yes	☐No
Early Morning use	Do you ever use early in the day to overcome a hangover or other effects of drinking or using drugs the night before?	☐Yes	☐No

PRIOR SUBSTANCE TREATMENT HISTORY

DATE OF Tx	NAME OF SUBSTANCE(S) ABUSED	NAME OF PROVIDER/AGENCY	TYPE OF Tx	RESPONSE TO Tx

ALCOHOL

TYPE OF ALCOHOL	AGE 1ST USE	DAYS USED IN LAST 30 DAYS	AMOUNT	FREQUENCY

DRUGS

TYPE OF DRUG	AGE 1ST USE	DAYS USED IN LAST 30 DAYS	AMOUNT	FREQUENCY	ROUTE OF ADMINISTRATION

Have you ever developed physical problems (i.e. enlarged liver, weight gain or loss, ulcers, high blood pressure) as a result of your chemical/alcohol use? ☐**Yes** ☐**No** Explain:

COMPULSIVE BEHAVIORS

Do you gamble (i.e. betting, lotteries, casinos, poker)? ☐**Yes** ☐**No**	Do you think you have a gambling problem? ☐**Yes** ☐**No**
How many times have you gambled in the last 30 days? ☐**Yes** ☐**No**	Do you mislead people important to you about your gambling?☐**Yes** ☐**No**
Do you ever gamble more than you intend? ☐**Yes** ☐**No**	Have you been told you have a compulsive gambling problem?☐**Yes** ☐**No**

Have you had problems with any of these compulsive behaviors: ☐ **N/A** ☐ INTERNET ☐ PORNOGRAPHY ☐ SHOPPING/DEBT ☐ SHOPLIFTING

If any gambling or complusive problem is present, please explain:

HOW HAVE THE FOLLOWING BEEN AFFECTED BY THE ALCOHOL/DRUG USE/COMPLUSIVE BEHAVIOR(S)?

Social Relationships:

Intimate Relationships:

Family:

Occupational/School/Job:

Emotional:

Financial:

Legal (OWI/DUI):

Medical:

Have you lost friends and/or other significant relationships as a result of your chemical use? ☐Yes ☐No

If yes, please explain:

SYMPTOMS OF SUBSTANCE USE

☐ Weekly use to being high or intoxication	☐ Repeated attempts to control use	☐ Solitary use/Using alone
☐ Tolerance (needing more to get the same effect)	☐ Drug or alcohol related legal problems	☐ Secretive use
☐ Becoming intoxicated to funtion in a social setting	☐ Binge use (remaining intoxicated for 3 days)	☐ Protecting one's supply
☐ Withdrawal or hangovers	☐ Other legal problems	☐ Using to medicate
☐ Driving when under the influence	☐ Blackouts (not remembering the using events)	☐ IV use - use by injecting
☐ Using in the morning to relieve symptoms	☐ Repeated family or social problems	☐ Mood swings
☐ Excessive spending on drugs/alcohol	☐ Using despite a serious medical problem	☐ Rapid intake to get a buzz
☐ Daily use	☐ Preoccupation (spending time planning to use)	☐ Passing out from using
☐ Loss of friends due to intoxicated/high behavior	☐ Giving up or reducing activities to use	☐ Loss of Control
☐ Inability to stop use	☐ Family history of addiction	☐ Shakes/Tremors (DT's)
☐ Failure to meet obligations at work, school, home	☐ Frequently using larger amounts than planned	☐ Physical Deterioration

Rationale for drug use:

Living environment pertinent to substance use:

Longest abstinence (date and year):

Signs of compulsion & loss of control:

Signs of preoccupation:

Signs of tolerence:

☐ Sweating (rapid pulse)	☐ Fever	☐ Hand tremors	☐ Dizziness
☐ Psychomotor agitation	☐ Delirium	☐ Headache	☐ GI upset
☐ Depression	☐ Fatique	☐ Anxiety	☐ Irritability
☐ Muscle aches	☐ Vivid, unpleasent dreams	☐ Tearing and runny nose	☐ Increase appetite
☐ Goose flesh	☐ Increased perception of sound	☐ Diarrhea	☐ No withdrawal symptoms

What are your relapse triggers?

What is your mental health like during sober periods?

MOTIVATION FOR CHANGE (Check all that applies)

☐ Precomtemplation	I have little intention of changing my drinking/drug use pattern in the near future.
☐ Contemplation	I intend to significantly reduce or stop drinking/using drugs in the near future.
☐ Preparation	I have recently taken small steps to reduce/stop/using drugs in the near future.
☐ Action	I significantly reduced or stopped drinking/using drugs within the past 6 mos.
☐ Maintenance	I significantly reduced/stopped drinking/using drugs over 6 mos. ago.

What factors led you to seek substance use treatment at this time? (Check all that applies)

☐ Legal Problems ☐ Health Problems ☐Financial Problems ☐ Relationship Problems ☐ School Problems ☐ Work Problems ☐ Other

Please explain:

SOCIOCULTURAL BACKGROUND

MILITARY HISTORY (☐ NOT APPLICABLE)

Branch of Service:	How Long?	Rank at Discharge:	Type of Discharge:
Combat Duty? ☐Yes ☐No	If yes, when and where?		

ETHNICITY/CULTURE/SPIRITUALITY

☐ Hispanic ☐ American Indian ☐ Asian ☐ African American ☐ Pacific Islander ☐ White ☐ Other:_____

Role of religious/spiritual(s)/value(s) in childhood? ☐Yes ☐No If yes, please explain:

Role of religious/spiritual(s)/value(s) as an adult? ☐Yes ☐No If yes, please explain:

Do you have a faith system/spirituality/religious preference? ☐Yes ☐No If yes, please explain:

If yes, are you actively involved? ☐Yes ☐No If yes, please explain:

Do you have a current place of worship/church? ☐Yes ☐No If yes, list place of worship/church:

EMPLOYMENT & OCCUPATIONAL STATUS

☐ Full-Time ☐ Part-Time ☐ Homemaker ☐ Unemployment ☐ Student ☐ Retired ☐ Other:_____

Job Title:	Employer:	How long at current job?

Level of Present Job Satisfaction? ☐ HIGH ☐AVERAGE ☐ LOW ☐ VERY LOW

LEGAL INFORMATION

Are you under any court order to seek counseling? ☐Yes ☐No If yes, explain:

Were you recommended to seek counseling from court/lawyer/attorney? ☐Yes ☐No If yes, explain:

Have you ever been convicted of operating a vehicle while intoxicated? ☐Yes ☐No If yes, explain:

Are you presently on probation? ☐Yes ☐No If yes, explain:

Name of Probation Officer:	Phone Number:

If you would like counselor to connect with your probation officer, please fill out the release of information for your probation officer.

PSYCHIATRIC/PSYCHOLOGICAL HISTORY

Are you presently receiving, or have you ever had any psychiatric/psychological care or counseling? ☐Yes ☐No

DATE OF Tx	DIAGNOSIS(S)	CLINIC/AGENCY	PROVIDER NAME	TYPE OF Tx (e.g.Outpatient)	RESPONSE TO Tx

Does (has) any other family members have (had) any psychiatric treatment? ☐Yes ☐No If yes, explain:

Did/have you had any prior suicidal attempts? ☐Yes ☐No If yes, explain:

Do you have any current suicidality/suicidal ideation? ☐Yes ☐No If yes, explain:

Did/have you had any incident (s) involving self-harm? ☐Yes ☐No If yes, explain:

Are there any guns in your residence? ☐Yes ☐No If yes, where are they kept?

Do you have any concern about, or been treated for: ☐ Gambling ☐ Shopping ☐ Porn/Sexual Addiction ☐ Hoarding ☐ NA

If yes, please explain:

PRESENTING SYMPTOMS

(Check all that applies)

☐ Alcohol Abuse	☐ Eating Problems	☐ Memory problems	☐ Shyness
☐ Anxiety	☐ Excessive sleepiness	☐ Nightmares	☐ Sleep Difficulties
☐ Back Pain	☐ Excessive Worries	☐ Overactive	☐ Stomach aches
☐ Bed-wetting	☐ Explosive Behavior	☐ Overeating	☐ Suicidal Thoughts
☐ Boredom	☐ Fainting/dizzy spells	☐ Panic symptoms	☐ Truancy
☐ Bowel disturbances	☐ Fatigue	☐ Physical pain	☐ Unusual Habits
☐ Compulsiveness	☐ Fears	☐ Restlessness, hyperactive	☐ Victim Physical Abuse
☐ Concentration issues	☐ Financial Problems	☐ Running away	☐ Victim-Emotional
☐ Deceitfulness	☐ Headaches	☐ School/Work Problems	☐ Victim-Sexual Abuse
☐ Depression	☐ Impulsiveness	☐ Sexual Problems	☐ Victim-Verbal Abuse
☐ Drug abuse	☐ Irritability	☐ Short attention span	☐ Victim-Violent Crime

Have you ever experienced abuse? ☐Yes ☐No If yes, explain:

Are there any past or current trauma(s)? ☐Yes ☐No If yes, explain:

Have you ever caused harm to another person physically or emotionally? ☐Yes ☐No If yes, explain:

Have you experienced any recent changes/losses? ☐Yes ☐No If yes, explain:

MEDICAL HISTORY

What, in your opinion, is the state of your health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

PERSONAL (FAMILY) PHYSICIAN:	PHONE NUMBER:

May we contact him/her for collateral information? ☐Yes ☐No **If yes, please fill out the release of information form.**

Are you presently receiving medical treatment? ☐Yes ☐No If yes, please list:

Do you have any significant health problems or injuries that have been treated in the past? ☐Yes ☐No If yes, please list:

Do you have any history of the following:

☐ Yes ☐ No **Hospitalization**	If yes, explain:
☐ Yes ☐ No **Major Accident**	If yes, explain:
☐ Yes ☐ No **Seizures**	If yes, explain:
☐ Yes ☐ No **Head Injury**	If yes, explain:
☐ Yes ☐ No **Loss Consciousness**	If yes, explain:
☐ Yes ☐ No **Current Pain**	If yes, explain and rate the 1-10: **1-2-3-4-5-6-7-8-9-10**

List any known allergies or any allergic reactions to medications:

MEDICATIONS

Medication	Dosage	Frequency	Prescriber

Do you have any concern about, or been treated for, any or all of the following?

Sexually Transmitted Diseases ☐Yes ☐No If yes, explain:

Hepatitis B or C ☐Yes ☐No If yes, explain:

Tuberculosis (TB) ☐Yes ☐No If yes, explain:

HIV ☐Yes ☐No If yes, explain:

Would you like any further information or referral regarding any of these? ☐Yes ☐No

ADDITIONAL INFORMATION

In your own words what do you see as your strengths and challenges:

Strengths:

Challenges:

Who is in your support system?

On a scale of 1 (low) to 10 (high), how would you rate your current functioning?

1 2 3 4 5 6 7 8 9 10

On a scale of 1 (mild) to 10 (totally impacting), how would you rate the severity of your issues?

1 2 3 4 5 6 7 8 9 10

What do you hope to accomplish in treatment?

CLIENT SIGNATURE		DATE SIGNED
PARENT/GUARDIAN SIGNATURE - If client is under 18	RELATIONSHIP TO CLIENT	DATE SIGNED