Lillybrook
In Times of Struggle, We Are Here

ACCT#: _____

Screening Information

ADULT

Please Print Clearly

Date: _____

Readmit: ____ Yes ____ No

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: Home _____ Work _____ Cell _____

Ok to leave messages? Home: ____ Yes ____ No Work: ____ Yes ____ No Cell: ____ Yes ____ No

Birthdate: _____ Age: _____ Gender: ____ F ____ M Race: _____

Would you like to receive a monthly newsletter: Yes please, my email is _____ No thank you __

Emergency Information

In case of emergency, contact:

1. Name: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

2. Name: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Employment Information

Client/Guardian: Place: _____ Occupation: _____

Spouse: Place: _____ Occupation: _____

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

Contract/ID#: _____ Contract/ID#: _____

Group/Acct#: _____ Group/Acct#: _____

Subscriber: _____ Subscriber: _____

Subscriber Date of Birth: _____ Subscriber Date of Birth: _____

Client's relationship to subscriber: _____ Client's relationship to subscriber: _____

Referral Source

How did you hear about Lillybrook Counseling Services (or from whom)? _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____

If you need any more space for any of the questions, please use the back of the sheet.

Do you have a ___ conservator ___ guardian ___ representative payee ___ personal representative

___No ___ Yes If Yes: Name: _____ Phone: _____

Address: _____

Is someone coordinating your services (e.g. legal, mental health, physical)?

___ No ___ Yes If Yes: Name: _____ Phone: _____

Address: _____

Primary reason(s) for seeking services:

___ Anger Management ___Anxiety ___Coping ___Depression ___Eating Disorder

___Fear/Phobias ___Mental Confusion ___Sexual Concerns ___Sleeping Problems ___Addictive Behaviors

___Alcohol/Drugs ___Past Trauma ___Other (please specify):_____

_____

_____

_____

How old were you when you first felt these symptoms? _____

What are you goals for therapy? (What outcome(s) would you like to take place?) _____

_____

Any additional information that would assist us in understanding your concerns or problems_____

_____

Behavioral/Emotional

___Alcohol dependence
___Aggressive (___Verbal ___Physical)
___Anger
___Anxiety
___Avoiding people
___Bizarre experiences
___Chest pain
___Computer addiction
___Depression
___Disorganized thoughts
___Disorientation
___Drug dependence
___Eating disorder
___Emotional outbursts
___Fatigue
___Gambling
___Hallucinations
___Hearing voices
___Heart palpitations
___High blood pressure
___Homicidal ideation
___Hopelessness
___Impulsivity
___Irritability
___Judgement errors
___Loneliness
___Memory impairment
___Overly sensitive
___Panic attacks
___Other: _____
___Paranoid
___Phobias/fears
___Racing thoughts
___Rapid speech
___Recurring thoughts
___Sexual addiction
___Sexual difficulties
___Sick often
___Sleeping Problems
___Social difficulties
___Speech problems
___Trembling
___Withdrawing
___Worrying

Please describe how the above symptoms impair your ability to function effectively (e.g. socially, occupationally, academically, emotionally, physically) _____

_____

_____

What areas of your life are being affected by the above?

Social
__ Unable to form or maintain friendships
__ Withdrawal from family and/or friends
__ Excessive desire to be alone
__ Increased conflict with others
__ Loss of interest in social activities
__Phobia

Occupational
__ Unable to maintain job
__ Absenteeism
__ Conflicts with co-workers
__ Tardiness
__ Reduced productivity
__ Disciplinary action for poor performance

Academic
__ Failing grades
__ Truancy
__ Tardiness
__ Detention
__ Reduced productivity
__ Fighting/conflicts with students/teachers

Physical
__ Decreased energy/fatigue (circle one)
__ Difficulty getting out of bed
__ Insomnia
__ Substantial weight loss or gain (circle one)
__ Decrease/increased appetite (circle one)
__ Frequent illness

Affective Distress
__ Crying spells
__ Worrying that interferes with the ability to concentrate
__ Irritability
__ Anger/Rage
__ Concentration problems
__ Emotional meltdowns/break downs
__ Disorganized thoughts
__ Memory problems
__ Feeling overwhelmed with emotions

Risk Assessment
__ Suicidality
__ Homicidality
__ Drug/Alcohol use
__ Unprotected sex
__ Cutting/Self-injury

Do you feel suicidal/homicidal at this time? ___ No ___ Yes
If Yes, explain: _____
_____

Are you engaged in any risk-taking behaviors? ___ No ___ Yes
If Yes, explain: _____
_____

Counseling/Prior Treatment History

	Yes	**No**	**When**	**Where**	**Overall Experience**
Mental health counseling	___	___	_____	_____	_____
	___	___	_____	_____	_____
	___	___	_____	_____	_____
Psychiatrist for medication	___	___	_____	_____	_____
	___	___	_____	_____	_____
Suicidal/homicidal thoughts	___	___	_____	_____	_____
Suicidal/homicidal attempts	___	___	_____	_____	_____
Drug/Alcohol Treatment	___	___	_____	_____	_____
Mental Health Hospitalizations	___	___	_____	_____	_____
Involvement with self-help groups (e.g. AA, Al-Anon, NA)	___	___	_____	_____	_____

Previous mental health diagnosis: _____
Any immediate family in treatment currently? If yes, whom and where? _____
_____

Family information

Your currently relationship status:

__ Single __Divorce in process __ Unmarried, living together
__ Legally married __ Separated __ Divorced
__ Widowed __ Annulment __ Engaged
__ Other: _____

Assessment of relationship with significant other (if applicable) __ Good __ Fair __ Poor __ NA

Would you like your family to be involved in your treatment? __ No __ Yes
If yes, please describe the extent of involvement: _____

	Name	Age	Indicate if step or adopted	Living? Yes/No	Living with you? Yes/No
Spouse					
Children					
Mother					
Father					

Significant others in your life (brothers, sisters, grandparents, relatives, step-relatives):
Please specify relationship

Relationship	Name	Age	Living? Yes/No	Living with you? Yes/No

Parental Information (Check those that apply)

__ Parents Legally married __ Mother remarried, Number of times ___
__ Parents have been separated __ Father remarried, Number of times ___
__ Parents ever divorced, Your age at time of divorce____
Special circumstances (e.g. raised by person other than parents, information about spouse/children not living with you, etc.)

_____

_____

Development

Are there special, unusual, or traumatic circumstances that occurred in your life? __ No __ Yes
If yes, please describe _____

_____

_____

Has there been history of child abuse? __ No __ Yes
If yes, which type(s)? __ Sexual __ Physical __ Verbal __ Emotional
Other childhood issues: __ Neglect __ Inadequate nutrition __ Poor health __ Other: _____

_____

How old were you at time of abuse? _____

Comments regarding childhood development: _____

_____

_____

Parenting style of parents
__ Authoritative (strict, but fair) __ Authoritarian (overly strict) __ Permissive (few rules) __ Passive (limited involvement)
In your developmental milestones (walking, talking, onset of puberty, etc.) were you: __ On time __ Early __ Late

Social Relationships
Check how you generally get along with other people (check all that apply)
__ Affectionate __ Aggressive __ Avoidant __ Fight/argue often __ Follower
__ Friendly __ Leader __ Outgoing __ Shy/Withdrawn __ Submissive
__ Other: _____

Do you currently have supportive friendships? __ No __ Yes

Sexual orientation _____ Comments _____
Sexual dysfunctions? __ No __ Yes If yes, please describe: _____

_____

Other History of Trauma
Any history of being abused by others? __ No __ Yes
__ Experienced: __ Witnessed: __ Neglect __ Abuse (__ Emotional __ Physical __ Verbal __ Sexual)
__ Violence __ Sexual assault
Explain: _____

_____

_____

Any current behaviors or history as sexual perpetrator? __ No __ Yes
If yes, describe _____

_____

_____

Do you have a history of social problems (e.g. being bullied, bullying others, difficulty making friends, etc..)? __ No __ Yes
If yes, describe _____

_____

_____

Cultural/Ethnic
To which cultural or ethnic group, if any, do you belong? _____
Are you experiencing any problems due to cultural or ethnic issues? __ No __ Yes
If yes, describe _____

_____

_____

Other cultural/ethnic information _____

Spiritual/Religious

How important are spiritual matters to you? __Not at all __Little ___ Moderate ___Much
Are you affiliated with a spiritual or religious group? __ No __ Yes
If yes, please describe _____
Were you raised within a spiritual or religious group? __ No __ Yes
If yes, please describe _____
Would you like your spiritual/religious beliefs incorporated into the counseling? __ No __ Yes
If yes, describe_____

Current Legal Status

Are you mandated for treatment? __ No __ Yes
Are you involved in any active cases (traffic, civil, criminal)? __No __ Yes
If yes, please describe and indicate the court and hearing/trial dates and charges_____

_____

Are you presently on probation or parole? __ No __ Yes
If yes, please describe _____
Probation officers name and telephone number:
_____

Past Legal History

	Yes	**No**
Traffic Violations		
Criminal involvement		
DWI, DUI, etc.		
Civil involvement		

If you responded yes to any of the above, please fill in the following information

Charges	**Date**	**Where (city)**	**Results**

Education

Fill in all that apply
Currently enrolled in school __ No __ Yes
__ High school grad/GED Average grades (current or previous) _____
__ Vocational Number of years ___ Graduated __ No __ Yes Major _____
__ College Number of years ___ Graduated __ No __ Yes Major_____
__ Graduate Number of years ___ Graduated __ No __ Yes Major_____
Special circumstances (e.g. learning disability, gifted)_____

Employment

Begin with most recent job

Employer	**Dates**	**Title**	**Reason left job**	**How often miss work**

Work Status

__ Full Time __ Part Time __ Temp __ Laid-off __Disabled __Retired __ Social Security
__ Student __Other:_____

Current Annual Income: Personal Income $_____ Household Income $_____

Military

Military experience? __ No __ Yes Combat experience? __ No __ Yes # of Tours _____
Branch _____ Discharge Date_____
Type of discharge _____ Rank at discharge _____
Family member in service? __ No __ Yes Who? _____

Leisure/Recreational

Describe special areas of interest of hobbies (e.g. art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?

Medical/Physical/Health

Please list all of your CURRENT medications (prescription and over the counter):

Name of medication	What do you use it for?	When did you begin taking it (year)	What is the strength/dosage	How often is it taken	Name of prescribing physician

Please list all of your PAST medications (prescriptions and over the counter):

Name of medication	What was it used for?	How long did you take it?	When did you stop taking it?	Why was it stopped?	Was the medication effective?

Describe your overall compliance with the above medications_____
Please list any nutritional and herbal supplements that you currently take _____
_____
Medication Allergies: _____
Have you ever had any bad reactions (made you feel worse) to prior medications? If yes, describe _____
_____
Do you see a psychiatrist? Name: _____ Last appointment: _____
Hospital of choice _____ Phone _____
Address _____

Most recent examinations:

Type of examination	Date of most recent visit	Reason/Results
Physical exam/Well visit		
Doctor's visit		
Dental examination		
Vision exam		
Hearing exam		
Surgery		
Upcoming surgery		

Self-Care

Sleep:

How many hours of sleep do you receive in a typical night? _____ Hours
Any problems: __ Falling asleep __ Staying asleep
How many hours of sleep do you need to feel rested? _____ Hours

Nutrition

How many consistent meals are you eating/day?_____
Quantity consumed at meals __Low __Medium __High
Explain:_____
Quality of food eaten __Low __Medium __High
Explain:_____

Exercise

Do you receive regular exercise? Explain type:_____
How often _____week/month
How long do you exercise? _____ min/hours

Disabilities

Do you have any physical/psychological disabilities? __No __Yes
If yes, describe and note how it affects your physical and/or psychological functioning and how you adjust to your disability(ies):
_____
Have you made an adjustment to the disability/disorder? __N0 __ Yes
Do you have any need for assistive technology in the provision of counseling services? __No __ Yes
If yes, explaim:_____

For each illness listed below, choose a single answer that best describes your health history:

Condition	Currently	In the past	Never	Condition	Currently	In the past	Never
Abortion				Loss of consciousness			
Anemia				Memory loss			
Appetite change				Numbness			
Arthritis				Pain (Daily, longer than 2 weeks)			
Asthma				Palpitations			
Back pain				Paralysis			
Blood in stool				Rheumatic fever			
Blurred vision				Seizures			
Caffeine use				Shortness of breath			
Chest pain				Skin disease			
Chicken pox				Sleep apnea			
Chronic cough				Sleep difficulties			
Colitis or Irritable Bowel				Stroke or TIA			
Confusion or disorientation				Swallowing difficulty			
Constipation				Dental problems			
Diabetes				Thyroid disease			
Diarrhea				Tuberculosis			
Dizziness				Ulcers or indigestion			
Emphysema				Urination difficulty			
Fainting				Sexually Transmitted Infections			
Glaucoma				Weakness			
Gluten allergy				Recent weight gain			
Head injury				Recent weight loss			
Headaches (Frequent)				Malnutrition			
Hearing loss				Epilepsy			
Heart disease				Autoimmune condition			
Miscarriage				Hepatitis			
Infertility				Low energy level			
Low libido				Other:			
Multiple sclerosis							

List any other current health concerns_____

_____

_____

List any recent health or physical changes_____

_____

_____

List YOUR history of mental illness/substance abuse

Personal History of:	**Currently**	**In the Past**	**Never**
Substance Abuse			
Depression			
Anxiety			
Bipolar			
Suicide/Homicide Attempt			
Nervous Breakdown			
Addictive Behaviors (eating, sexual, etc.)			
Psychiatric Hospitalizations			

List FAMILY history of mental illness/substance use:
Mother = Mo; Father = Fa; Sibling = S; Grandmother = Gm; Grandfather = Gf

Family History of:	**Currently**	**In the Past**	**Never**
Substance Abuse			
Depression			
Anxiety			
Bipolar			
Suicide/Homicide Attempt			
Nervous Breakdown			
Addictive Behaviors (eating, sexual, etc.)			
Psychiatric Hospitalizations			

Do any of these illnesses significantly challenge or limit your ability to function at work or at home? If yes, please describe in detail:

_____

_____

_____

_____

Substance Use History

Drug Type	Method	Age at first use	Age at last use	Age of onset of heavy use	Number of days used in the last 30	Used in last 48 hours?	Used as a rx?	Date of last use	Amount used daily	Amount used weekly	Drug of choice
Alcohol											
Heroine											
Other opiates/painkillers											
Barbiturates/ Sedatives											
Other sedatives											
Tranquilizers											
Meth/Stimulants											
Cocaine											
Crack											
Hallucinogens/ PCP											
Cannabis											
Inhalants											
Antidepressants											
Over the counter											
Nicotine											
Caffeine											
Steroids											
Methadone/ Suboxone											
Benzodiazepines											
Other											

Substance(s) of preference

1. _____ 3. _____

2. _____ 4. _____

Describe when and where you typically use substances _____
_____

Describe any changes in your use patterns_____
_____

Describe how your use has affected your family or friends (include their perceptions of your use) _____
_____

Reason for use
__ Addicted __Build confidence __Escape __Self-medication
__Socialization __Taste __Other_____
How do you believe your substance use affects your life?_____
Who or what has helped you in stopping or limiting your use?_____
Does/Has someone in your family present/past have/had a problem with drugs or alcohol? __No __Yes
If yes, describe_____

Substance Abuse History Continued

___Has your use of alcohol or drugs interfered with your obligations at work?
___Has your use of alcohol or drugs interfered with your obligations at school?
___Has your use of alcohol or drugs interfered with your obligations at home?
___Have you used alcohol or drugs while driving a car or truck?
___Have you used alcohol or drugs while operating machinery?
___Have you ever been arrested as a result of drinking or using drugs?
___Have you continued to use alcohol or drugs despite having problems caused by the effects of the substance?
___Have you ever used more alcohol or drugs in order to achieve the desired effect?
___Has there become a markedly diminished effect with the continued use of the same amount of the substance?
___Have you ever needed to take a drink or use a drug in the morning in order to relieve a hangover?
___Have you ever used substances in larger amounts or over a longer period of time than was initially intended?
___Have you attempted to cut down or control the amount of drinking or drug use without success?
___Have you spent a great amount of time in activities necessary to obtain the alcohol or drugs?
___Have important social, occupational, or recreational activities been given up or reduced because of your use of alcohol or drugs?
___Have you continued to use alcohol or drugs despite knowing that physical, psychological, or legal problems are likely to occur?

Personal Assessment

Personal Strengths (Circle all that apply):
Compromising Creative Cooperative Compassionate Friendly
Generous Hard Working Honest Intelligent Insightful
Open Minded Open to Therapy Sense of Humor Spirituality Willing to change
Other: _____

Individualized Needs (Circle all that apply):
Accessibility Case Management Child Care Clothing
Companionship Employment Finances Food Health Insurance
Heat Medical Services Medications Safety Shelter
Social Support Telephone Transportation Coping Skills
Other: _____

Abilities/Interests (Circle all that apply):
Financial Management Job Skills Leadership Organized
Reader Recreation Resourcefulness Social Skills Writing
Other: _____

Preferences (Please indicate):
Day: _____ Time: _____
Cultural/Religious/Sexual Considerations: _____
_____
Aftercare/Discharge planning: _____
Supports:_____
Other: _____

_____ _____
Signature of person filling out form Date

***DOCUMENT WILL BE REVIEWED DURING INTAKE AND DOCUMENTED ON THE INTAKE ASSESSMENT.**