Circle of Life Counseling, LLC

Dorith Prutchi, MSS, LCSW – Licensed Clinical Social Worker

Intake Form

Thank you for choosing Circle of Life Counseling, LLC, if you need any assistance with the forms, we will be happy to assist you.

Client Information

Name: _____

Date of Birth: _____ Age: _____ Gender: (circle one) Male / Female /0ther

Home address: _____

Hone phone: _____ May I leave a message? _____

Cell phone: _____ May I leave a message? _____

May I txt you? _____

Email address: _____ May I contact you by email? _____

How did you hear about *Circle of life Counseling, LLC*? _____

Responsible Party – (if different than client)

Name of responsible party: _____

Relationship to client: _____

Date of birth: _____

Address: _____

Emergency Contact information:

Name: _____

Relationship to client: _____

Phone: _____

Marital Status: _____

If Married: for how long? _____

How stable is your marriage? _____

If divorced: How long: _____

If Widowed: How long? _____

Highest level of education _____

Year graduated _____ Degree _____

Occupation _____

Place of Business _____

How long in your current job? _____

How stressful is your current job? _____

Previous jobs that you held? _____

Religion background _____

How much is religion important for you? Very Much Some What Not at all

Race _____

Are you currently serving in the military? Yes No

Are you a veteran? Yes No

Medical History

Primary physician: _____ Phone_____

Date of last physical exam: _____

Current Psychiatrist: _____ Phone: _____

Last time you visited your psychiatrist: _____

In your words – what brought you here today?

_____
_____
_____
_____
_____
_____
_____

Medical Information:

Current Medication: (List psychiatric and or other medication including over the counter

Name of Medication Doze	Doze MG. / How many times	Rout By mouth? Injection?	Date Started	Reason	Effectiveness

Substance use history - Do you or someone close to you raised concerns about the following behaviors

Substance	Used in last six months			Past Use		
	Yes	No	How often, how much?	Yes	No	How often how much?
Tabaco						
Caffeine						
Alcohol						
Marijuana						
Crack / Cocaine						
Ecstasy						
Heroin						
Methamphetamines						
Pain Killers						
Tranquilizers						
Sleeping pills						
Other						

Please list any allergies / chronic pain or illness / SDT/ surgeries (including abortion) / miscarriage / head injury / serious accident or anything else that you think that might be important:

_____
_____
_____

_____
_____

Do you or someone close to you raised concerns about the following behaviors

	Me		Someone Else	
	Yes	No	Yes	No
Difficult Sustaining Attention				
Irritability				
Body Aches and Pains				
Diminished Pleasure in Activities				
Decrease or Increase of Appetite				
Insomnia or Excessive Sleeping Nearly Every Day				
Fatigue and/or Loss of Energy				
Feelings of Worthlessness and/or Hopelessness and/or Guilt				
Diminished Ability to Concentrate				
Suicidal Thoughts or Attempts				
Self-Harm Behaviors				
Dizzy or Lightheaded				
Faint or Lightheaded				
Indigestion				
Hot or Cold Sweats				
Scared				
Terrified or Afraid				
Feeling of Choking				
Fear of Losing Control				
Nervous				
Impulsivity				
Boredom				
Excessive Worry				
Panic Attacks				
Obsessive Thoughts				
Compulsive Behavior				
Flashbacks				
Hallucinations (Auditory or Visual)				
Alcohol or Drug Use				
Other				

List any family member suffering from or diagnosed by a professional with any of the following: Depression, Anxiety disorder, eating disorder, suicide or attempted suicide, ADHD, OCD, Alcohol or substance use.

_____
_____
_____
_____
_____
_____

Have any of the following stress events occurred within the past 12 months?

	Yes	No
Divorce / separation within the family?		
Family accident / illness.		
Death in the family?		
Loss / change of jobs?		
Family move?		
Financial problems?		

Social History:

Please list the individuals who currently live in your household:

Name	Age	Relationship to you	Quality of relationship	Conflicts

List names and addressed of all other professionals consulted in the past:

	When	Provider Name, address and telephone number
Outpatient Counseling		
Psychiatric Hospitalization		
Drug/ Alcohol Treatment		
Support Group		

Have you ever or currently had problems with the law? (Circle the one that pertains to you)

Yes No

If you answered "Yes" please explain:

_____
_____
_____
_____
_____

Are you currently involved in custody or divorce proceeding? (Circle the one that pertains to you)

Yes No

If you answered "yes" please explain:_____
_____
_____
_____
_____
_____

Are you currently involved in any other litigation? (Circle the one that pertains to you)

Yes No

If you answered "yes" please explain: