Laraine A. Tanzer, LCSW

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INTAKE FORM

Name: Date:

Street: City: State:

Zip: Home Phone: Cell Phone:

Employer: Work Phone:

Work Address: Occupation:

Sex: *Male* *Female* Ethnicity: Date of Birth: Age:

Marital status (circle all that apply): Single *Engaged* *Living together* *Married* *Separated* *Divorced* *Widowed*

Name of Spouse: Spouse's Employer:

E-mail: Referred by:

Names of Children:	Age	Gender	Living w/ you?	Comments:
________	____	*M F*	*Yes No*	________
________	____	*M F*	*Yes No*	________
________	____	*M F*	*Yes No*	________
________	____	*M F*	*Yes No*	________
________	____	*M F*	*Yes No*	________

Briefly state your reason for seeking counseling at this time:

Have you ever been seen by a mental health professional before? *Yes* *No*
If yes, please indicate who, when and why:

Would you consent for Laraine Tanzer, LCSW to contact him/her on your behalf? *Yes* *No*

Do you regularly practice relaxation techniques (e.g. meditation, yoga, Tai Chi)? *Yes* *No*

If yes, what and how often?____

How often do you get therapeutic massage? ____

How often do you get 20 minutes or more of exercise? ______________________________

How many caffeinated drinks (coffee, sodas, tea, hot chocolate) do you usually drink per day? _____

How many food and drink products containing NutraSweet do you usually consume each day? _____

How much do you usually smoke? ____

How much alcohol do you usually drink? ____

Do you use “recreational” drugs? *Yes* *No* If yes, what and how often? __________________

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Do you take vitamins and/or herbal remedies? *Yes* *No* If yes, what and how often? _________

____

Which category best describes your diet?

- *Very Healthy* (Lots of fresh fruits/vegetables/whole grains, and few sweets/fatty foods.)
- Between *Moderately Healthy* & *Very Healthy*
- *Moderately Healthy* (Some fresh fruits/vegetables/whole grains, and some sweets/fatty foods.)
- Between *Unhealthy* & *Moderately Healthy*
- *Unhealthy* (Few fresh fruits/vegetables/whole grains, and lots of sweets/fatty foods.)

Who is your primary physician? Phone #:

Please list any troublesome or significant medical conditions you may have.

Please list your current medications (Prescription & Non-Prescription):

Drug	Dose	Frequency	When Started	For what symptom(s)	Prescribing Doctor

Who should be notified in case of emergency?		
Name:		Relationship:
Home Phone:	Work Phone:	Pager:

Name **Date**

Symptom Frequency Scales

How often have you experienced the following symptoms over the last two weeks?

Depression	***Not at all***					***Sometimes***					***All the time***	✓ Drug Related
Feelings of sadness	0	1	2	3	4	5	6	7	8	9	10	
Difficulty falling asleep and/or staying asleep	0	1	2	3	4	5	6	7	8	9	10	
Desire to spend a lot of time sleeping	0	1	2	3	4	5	6	7	8	9	10	
Fatigue or loss of energy	0	1	2	3	4	5	6	7	8	9	10	
No interest in formerly pleasant activities	0	1	2	3	4	5	6	7	8	9	10	
Feelings of worthlessness	0	1	2	3	4	5	6	7	8	9	10	
Feelings of hopelessness	0	1	2	3	4	5	6	7	8	9	10	
Feelings of excessive and/or inappropriate guilt	0	1	2	3	4	5	6	7	8	9	10	
Thoughts of being punished	0	1	2	3	4	5	6	7	8	9	10	
Impaired ability to concentrate	0	1	2	3	4	5	6	7	8	9	10	
Indecisiveness	0	1	2	3	4	5	6	7	8	9	10	
Excessive appetite OR poor appetite	0	1	2	3	4	5	6	7	8	9	10	
Feelings of restlessness	0	1	2	3	4	5	6	7	8	9	10	
Sense of moving slowly	0	1	2	3	4	5	6	7	8	9	10	
Thoughts of death	0	1	2	3	4	5	6	7	8	9	10	
Thoughts of suicide	0	1	2	3	4	5	6	7	8	9	10	
Unplanned weight gain OR weight loss	NO	YES	If yes, how much?									

Anxiety	***Not at all***					***Sometimes***					***All the time***	✓ Drug Related
Inability to relax	0	1	2	3	4	5	6	7	8	9	10	
Nervousness	0	1	2	3	4	5	6	7	8	9	10	
Numbness or tingling	0	1	2	3	4	5	6	7	8	9	10	
Heart pounding or racing	0	1	2	3	4	5	6	7	8	9	10	
Indigestion and/or discomfort in abdomen	0	1	2	3	4	5	6	7	8	9	10	
Feelings of choking	0	1	2	3	4	5	6	7	8	9	10	
Shaky	0	1	2	3	4	5	6	7	8	9	10	
Scared	0	1	2	3	4	5	6	7	8	9	10	
Difficulty breathing	0	1	2	3	4	5	6	7	8	9	10	
Racing thoughts	0	1	2	3	4	5	6	7	8	9	10	
Sweating (not due to heat)	0	1	2	3	4	5	6	7	8	9	10	
Dizziness or lightheaded	0	1	2	3	4	5	6	7	8	9	10	
Fear of the worst happening	0	1	2	3	4	5	6	7	8	9	10	
Fear of losing control	0	1	2	3	4	5	6	7	8	9	10	
Fear of dying	0	1	2	3	4	5	6	7	8	9	10	