Lenée N. Essig, LCSW, LLC 5810 Kingstowne Center Dr. Ste. 120-148, Alexandra VA 22315
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Intake Form for Individual Psychotherapy

General Information

Date:_____

Client Full Name:_____
First, Middle, Last

Home Address: _____
Street, City, State, Zip Code

Is it okay for you to receive mail at this address with my name on the return address label? ☐yes ☐no

Email address: _____ May I contact you via email? ☐yes ☐no

(Please be aware of the limits of confidentiality with email)

Cell Number: _____ Alternative Number (*work/home*): _____

May I leave a message on the above phone numbers: ☐yes ☐no

Are you a Medicare B recpient: ☐yes ☐no Are you a Tri-Care recpient: ☐yes ☐no

(Please note that Lenée N. Essig, LCSW, LLC is not a Medicare or TriCare Provider)

Place of Employment:

_____
Occupation / Place of Employment /Address

Do you enjoy your work? ☐Yes ☐No Is there anything stressful about your current work?

_____

_____

Birth Date: _____ Age: _____ How You Identify Your Gender: _____

Relationship Status: ☐Never Married ☐Married ☐Separated ☐Divorced

☐Widowed ☐Happily Single ☐Not So Happily Single ☐Not Married, in a committed relationship

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your present relationship and/or relationship history? _____

Spouse/Partner's Name: _____

Spouse/Partner's Age:_____ Identified Gender: _____

Spouse/Partner's Place of Employment*:*

_____
Occupation / Place of Employment / Address

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Children

1. Name: _____ Age: _____ Identified Gender: _____

School Name: _____

2. Name: _____ Age: _____ Identified Gender: _____

School Name: _____

Do all of the above children live with you? ☐Yes ☐No

If no, with whom do the children reside: _____

Address:_____

General Health, Medical, & Mental Health Information

How would you rate your current physical health? (Please check one)

Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good □

List any medical conditions you have:
1._____
2._____
3._____
4._____
5._____

List any medication you are currently taking:
1 _____ Dosage: _____
2._____ Dosage: _____
3._____ Dosage: _____
4._____ Dosage: _____
5._____ Dosage: _____

Prescriber Name, Phone Number and Address: _____

_____

How would you rate your current sleeping habits?

Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good □

Please list any specific sleep problems you are currently experiencing:

_____

_____

If you exercise, how many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

_____

Please list any difficulties you experience with your appetite or eating problems:

_____

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Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe: _____

_____

Please check any of the following that applies to you:

☐Headaches	☐Feelings of Inferiority	☐Always Worried
☐Dizziness	☐Feeling Tense	☐Don't Like Vacations/Weekends
☐Fainting Spells	☐Feeling Panicky	☐Challenges with Decision Making
☐No Appetite	☐Fears and Phobias	☐Overly-Ambitious
☐Over-Eating	☐Obsessive Thoughts/Behaviors	☐Financial Stress
☐Stomach Trouble	☐Gambling	☐Job Challenges
☐Bowel Disturbances	☐Suicidial Ideation	☐Afraid of People
☐Always Tired /Sleepy	☐Allergies	☐Fertility Concerns
☐Asthma	☐Friendship Challenges	☐Gender Identity Thoughts
☐Unable To Relax	☐Sexual/Intimacy Challenges	☐Sexual Identity Thoughts
☐Insomnia	☐Shy	
☐Recurrent Dreams	☐Nightmares	
☐Hallucinations	☐Unable to Enjoy Yourself	

Family Mental Health History

Please identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

Alcohol/Substance Abuse	Yes □ / No □	_____
Anxiety	Yes □ / No □	_____
Depression	Yes □ / No □	_____
Relationship/Domestic Violence	Yes □ / No □	_____
Eating Disorders	Yes □ / No □	_____
Obesity	Yes □ / No □	_____
Obsessive Compulsive Behavior	Yes □ / No □	_____
Schizophrenia	Yes □ / No □	_____
Suicidial Ideation/Attempts	Yes □ / No □	_____

Personal General Information

What do you consider to be some of your strengths? _____

_____

What do you consider to be some of your weaknesses? _____

_____

What significant life changes or stressful events have you experienced recently? _____

_____

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Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes

If yes, when did this begin? _____

What is your alcohol intake on a weekly basis? _____

Are you concerned with your alcohol intake? □ No □ Yes

How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently

Are you concerned with your drug use? □ No □ Yes

Any legal issues (past and present)? _____

_____

Leisure activities: _____

_____

Military history (family members in military, spouse, self): _____

_____

Personality patterns/Self-image (words you or others use to describe you): _____

_____

Description of childhood: _____

_____

Description of parents' relationship or of primary caregiver(s): _____

_____

Other important information about family of origin: _____

_____

_____

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Religious/Spiritual

Your beliefs systems are respected. If you do not wish to share your beliefs, you do not need to complete the following questions. What is your religious or spiritual point of view?_____

_____

How important are your beliefs to your life? Please check one.

Very Important ☐ Somewhat Important ☐ Minor Importance ☐

Clinical

What has brought you in today?_____

_____

_____

Please describe the presenting challenge(s) with current symptoms, as related to emotions, behaviors and thoughts:

_____

_____

History of presenting challenge(s):_____

_____

_____

Life changes/stresses (job, marital, children, pregnancies/abortions, relationships, legal, financial, health, housing, losses, abuse, addictions): _____

_____

Have you received therapy before? ☐Yes ☐No If yes, when and by whom? Type of Therapy?

_____

Have you ever been diagnosed or hospitalized for mental health issues, personality disorder, anxiety disorder, etc.? If yes, please describe._____

_____

Emergency Contact Information

Emergency contact & relationship (eg: Jane Smith / mother): _____

Emergency contact address & phone number: _____

Referral Source: Source of referral:_____