LEANNE L. EARNEST, Ph.D. INTAKE FORM

Date: _____ Marital Status: □ Married □ Single □ Divorced □ Widowed □ Separated

Name: _____Occupation: _____

Religion while growing up: □ none □ Jewish □ Protestant □ Catholic □ Buddhist □ other

Education □ Some High School □ High School Graduate □ Post High school Training □ College □ Graduate Work

What is the purpose of this visit? What kinds of problems have been going on?

_____
_____
_____
_____
_____

When did the problems start? _____ What do you think might have caused them?_____

_____
_____
_____

How long do you think it will take to take care of them? _____
How motivated are you to do something about them (on a scale of 1-10 with 10 them most motivated)? _____

CURRENT PROBLEM AREAS						
PLEASE CHECK YOUR RESPONSE		NOT A PROBLEM	MILD PROBLEM	MODERATE PROBLEM	SEVERE PROBLEM	RATE YOUR OVERALL LEVEL OF DISTRESS:
1	Financial problems	□	□	□	□	
2	Physical health and/or handicap	□	□	□	□	□ Mild
3	Misuse of drugs or alcohol	□	□	□	□	□ Moderate
4	Spiritual concerns	□	□	□	□	□ Severe
5	Sexual concerns	□	□	□	□	
6	Problems with children	□	□	□	□	HOW LONG HAVE YOU BEEN EXPERIENCING THESE PROBLEMS?
7	Problems with parents	□	□	□	□	
8	Problems with spouse/partner	□	□	□	□	
9	Communication problems	□	□	□	□	□ Under 3 months
10	Problems with pregnancy	□	□	□	□	□ 3-6 months
11	Separation or divorce	□	□	□	□	□ 6-12 months
12	Problems with aging	□	□	□	□	□ 1-2 years
13	Trouble relating to others	□	□	□	□	□ 3- 4 years
14	Career problems	□	□	□	□	□ 5 or more years
15	Legal difficulties	□	□	□	□	
16	Lack of Self Esteem	□	□	□	□	
17	Food/body image issues	□	□	□	□	
18	Change of life problems	□	□	□	□	
19	Physical violence/abuse	□	□	□	□	
20	Other					

Comments:

PREVIOUS THERAPY HISTORY
Has there been any previous treatment for emotional problems, relationship problems or addiction? □ yes □ no
Where? With Whom?
Was medication used? □ yes □ no If so, what kind, how much, for how long?
Was hospitalization needed? □ yes □ no If so, how many times? Where? How long?
In your opinion, was any of the treatment helpful? □ yes □ no Please explain:

WHAT SYMPTOMS HAVE YOU BEEN FEELING? (PLEASE CHECK)					
□	Numb	□	"Used"/ Put Upon	□	Headaches
□	Depressed	□	Embarrassed	□	Worry
□	Hopeless	□	Shameful/ Inadequate	□	Racing thoughts
□	Confused	□	Lonely	□	Obsessive repetitious thoughts
□	Disappointed? Let Down	□	Guilty	□	Compulsive Behaviors (specify):
□	Empty	□	Trapped		
□	Sad	□	Fatigue		
□	Fearful	□	"Wired" Unable to Slow Down	□	Weight Gain
□	Panic Attacks	□	Sleep Problems	□	Weight Loss
□	Anxiety	□	Too much sleep	□	Memory Impairment
□	Nervousness	□	Not enough sleep	□	Trouble Concentrating
□	Tense	□	Nightmares	□	Hearing things
□	Anger	□	Flashbacks	□	Seeing things
□	Hostile/Violent	□		□	Other:
□	Resentful	□			
□		□			

HOW LONG HAVE YOU BEEN EXPERIENCING THESE SYMPTOMS/FEELINGS?							
□	Under 3 months	□	6 – 12 months	□	3 - 4 years	□	All My Life
□	3 - 6 months	□	1- 2 years	□	5 or more years	□	

Comments:

BACKGROUND			
IDENTIFY AREAS OF CONCERN THAT APPLY TO YOU OR A FAMILY MEMBER.			
Write in self, mother, father, brother, spouse, partner, child in the space provided.			
□	Smoker	□	Food Eating Disorders
□	Alcohol Abuse	□	Compulsive Eater
□	Other Drug Abuse	□	Bulimic
□	Drug Dependent	□	Anorexic
□	Too religious	□	Exercise Addict
□	Helpless/victim	□	Numerous Affairs
□	Pleaser	□	Sexually Abusive
□	"Picture Perfect"	□	Emotionally Abusive
□	Too Positive	□	Physically Abusive
□	Too Negative	□	Panic/Anxiety Attacks
□	Rageaholic	□	Too Dependent
□	Compulsive Cleaner	□	Too Independent
□	All rational/ nonfeeling	□	Depression
□	Compulsive Gambler	□	Workaholic
□	Other	□	Chronic Mental Illness/ Diagnosis:
□	Other	□	Chronic Physical Illness. Disease:
□		□	

Comments:

DEVELOPMENT

Was your birth out of the ordinary in any way or were there any serious MEDICAL PROBLEMS? □ yes □no
□ Before age 3? □ Between 3 and 5 years? □ 5 and 10 years? □ 10 and 18 years?
Please explain: _____
_____
_____

During the first six months of life, were there problems with growth or function? □ yes □no
Please explain: _____
_____
_____

Were there any DELAYS or problems with (circle all that apply) SLEEPING, EATING, GROWING, CRAWLING, WALKING, TALKING OR SPEAKING, TOILET TRAINING, PLAYING, COORDINATION? □ yes □no
Please explain: _____
_____
_____

Is there any history of difficult TEMPERMENT or poor ACCEPTANCE by the family?
How would you describe yourself as a child? □ leader □ follower □ shy □ fearful □ aggressive □ fearless □ other:
_____

Who raised you as a child? _____
_____

How many brothers and sisters did you have? _____
What number child are you? □ Only □ First □ 2nd □ 3rd □ _____
Which parent were you closer to as a child? □ Mother □ Father □ Both the same

Childhood punishments? (check all that apply) □ spanking □ time out □ grounded □ points □ natural consequences □ other
Did you ever feel that your parents lost control? □ yes □no
Explain:

Any DIFFICULTIES (circle all that apply) being AWAY from home, REFUSED to go to school, trouble LEARNING, paying ATTENTION? Complaints of stomach or other PAINS when upset? Have trouble GETTING ALONG with kids, teachers or other adults? □ yes □no
Please explain: _____
_____
_____

Any experiences of Serious LOSS, ABUSE, SEPARATIONS, witness abuse or other painful experiences? □ yes □no
Please explain: _____
_____
_____

HEALTH

When was your last complete physical? _____ Physician: _____
Any current or past MEDICAL PROBLEMS (circle the ones that apply)

asthma or other breathing problems	frequent coughing	coughing blood	fever
arm, leg, or other joint pain	motion sickness	stomach aches	nausea
jaundice or other liver problems	vomiting	bloody stools	diarrhea
unusual weight gain or loss	constipation	rash	allergies
unusual or early sexual behavior	anemia	diabetes	thyroid
kidney problems	heart problems	murmur	leg swelling
problems sleeping	bed wetting	back problems	drug problems
headaches	seizures	convulsions	epilepsy
black-outs	head injury		

Other: _____
_____
_____
_____

Have any BLOOD relatives had HEART PROBLEMS or died from unknown causes? ☐ yes ☐ no
Have you had an EKG (heart monitor)? ☐ yes ☐ no Was it abnormal? ☐ yes ☐ no
Had a head injury, an EEG (brain wave test) or seen a neurologist (brain specialist)? ☐ yes ☐ no
Any ALLERGIES to medications? ☐ yes ☐ no
Which one(s)?_____

Are you taking any MEDICATIONS or receiving any TREATMENTS? ☐ yes ☐ no

name and amount	**times/day**	**purpose**	**DOCTOR**

Explanation_____
_____
_____

Is your diet poor? ☐ yes In what way? _____ ☐ no
How many CAFFEINATED beverages (e.g., colas, tea, coffee) does you drink each day?
Are you ☐ having monthly periods? ☐ pregnant? ☐ using birth control? □ using hormone replacement therapy?

CURRENT HISTORY

Please list below everyone who is living in your home.

Name	Age	Relationship

Are you feeling suicidal? □ yes □no

Have you ever had suicidal thoughts? □ yes □no If yes, How recently? _____

Have you made a plan to commit suicide? □ yes □no

What might be causing you stress at this time? _____

What would make you feel better: _____

How satisfied are you with

- Your work?_____
- Your social life, friendships?_____
- Your intimate life?_____
- Your sexuality?_____
- Your spiritual life? _____
- Hobbies? _____

Please include any other information you think would be helpful for me to know about you.

_____
_____
_____
_____
_____
_____
_____
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_____
_____