Lola Georg, MS
Licensed Professional Counselor
Georg Associates www.GeorgAssociates.com
LolaGeorgLPC@gmail.com
484-324-8370 (phone or text)

INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Name: _____

Name of parent/guardian (if under 18 years):_____

Birth Date: _____ /_____ /_____ Age: _____ Gender: _____

Preferred Pronouns: _____

Relationship Status: _____

Please list any children and their ages: _____

_____

Address: _____

_____

Referred by: _____

Preferred Phone: _____
May we leave a voice message? □Yes □No May we leave a text message? □Yes □No

E-mail: _____
May we email you? □Yes □No ***Please note:*** Email correspondence is not considered to be a confidential medium of communication.

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No □ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? □ Yes □ No

Please list: _____

_____

Have you ever been prescribed psychiatric medication? □ Yes □ No

Please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

Please check any of the following symptoms or issues that may apply to your situation. Add comments if applicable.

□ Sad Mood _____

□ Low Energy or Fatigue _____

□ Hopelessness _____

□ Worthlessness _____

□ Crying Spells _____

□ Guilt _____

□ Decreased Motivation _____

□ Loss of Interest in Usual Activities _____

□ Irritability _____

□ Hyperactivity _____

□ Impulsiveness _____

□ Elevated Mood _____

□ Racing Thoughts _____

□ Concentration or Memory Difficulties _____

□ Change in Sexual Interest _____

□ Sexuality _____

□ Gender _____

□ Change in Appetite _____

□ Difficulty in Falling Asleep _____

□ Excessive Sleeping _____

□ Suicidal Thoughts _____

□ Anxious or Worried _____

□ Panic Attacks _____

□ Fear of Leaving Home _____

□ Fear of Situations or Things _____

□ Upsetting Thoughts _____

□ Repetitive Thoughts or Behaviors _____

□ Obsessions _____

□ Gaps in Memory _____

□ Excessive Anger or Aggression _____

□ Difficulty Trusting Others _____

□ Binging or Purging _____

□ Rebellious or Defiant _____

□ Trauma _____

□ Abuse _____

□ Domestic Violence _____

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health challenges you are currently experiencing:

_____

_____

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

How many times per week do you generally exercise? _____

What types of exercise to you participate in: _____

Are you currently experiencing overwhelming sadness, grief or depression?

□ No □ Yes - If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias?

□ No □ Yes - If yes, when did you begin experiencing this? _____

Are you experiencing any chronic pain?

□ No □ Yes - If yes, please describe? _____

Do you drink alcohol more than once a week? □ No □ Yes

How often do you engage recreational drug use? □ Daily □ Weekly □ Infrequently □ Not at all

Are you currently in a romantic relationship?

□ No □ Yes - If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

What significant life changes or stressful events have you experienced recently:

_____

_____

FAMILY MENTAL HEALTH HISTORY

In the section below 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 (parent, grandparent, sibling, etc.).

Alcohol/Substance Abuse _____

Anxiety _____

Depression _____

Domestic Violence _____

Bipolar Disorder _____

Eating Disorders _____

Suicide Attempts _____

Schizophrenia _____

ADDITIONAL INFORMATION

Are you currently employed? □ No □ Yes - If yes, what is your current employment situation:

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

Do you consider yourself to be spiritual or religious?

□ No □ Yes If yes, describe your faith or belief:_____

What do you consider to be some of your strengths?

_____

_____

What do you consider to be some of your weakness?

_____

_____

What would you like to accomplish during your time in counseling?

_____

_____

Do you have any questions about counseling?

_____

_____