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**Licensed Professional Counselor**  
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484-324-8370 (phone or text)

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## 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: \_\_\_\_\_

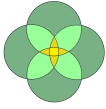
May we leave a voice message? Yes No    May we leave a text message? Yes No

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: \_\_\_\_\_

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### 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 \_\_\_\_\_

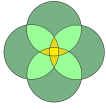
Loss of Interest in Usual Activities \_\_\_\_\_

Irritability \_\_\_\_\_

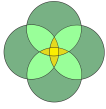
Hyperactivity \_\_\_\_\_

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:

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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:

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How many times per week do you generally exercise? \_\_\_\_\_

What types of exercise do you participate in: \_\_\_\_\_

Are you currently experiencing overwhelming sadness, grief or depression?

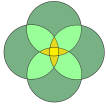
No     Yes - If yes, for approximately how long? \_\_\_\_\_

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 \_\_\_\_\_

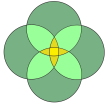
Domestic Violence \_\_\_\_\_

Bipolar Disorder \_\_\_\_\_

Eating Disorders \_\_\_\_\_

Suicide Attempts \_\_\_\_\_

Schizophrenia \_\_\_\_\_



**ADDITIONAL INFORMATION**

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

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

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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?

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What do you consider to be some of your weakness?

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

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Do you have any questions about counseling?

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