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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: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

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: \_\_\_\_\_

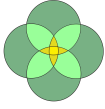
May we email you? Yes No

**Please note:** Text, phone and email communications are not considered to be a confidential forms of communication.

Emergency Contact Person: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Phone Number: \_\_\_\_\_



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Have you previously received any type of mental health services (counseling, psychotherapy, psychiatric services, etc.)?  No  Yes, previous counselor/practitioner(s):

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Are you currently taking any prescription psychiatric medication?  Yes  No

Please list medication(s) and dosage(s):

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Who prescribes your psychiatric medication?

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Are you currently taking any other prescription medication?  Yes  No

Please list medication(s) and dosage (s):

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### GENERAL HEALTH INFORMATION

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

Poor    Unsatisfactory    Satisfactory    Good    Very good

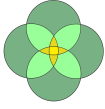
Please list any specific health challenges you are currently experiencing:

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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:



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 romantic relationship(s)?

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

On a scale of 1-10, how would you rate your relationship(s)? \_\_\_\_\_

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

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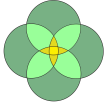
### **FAMILY MENTAL HEALTH HISTORY**

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 \_\_\_\_\_



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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?

\_\_\_\_\_