Ashley Cygnarowicz, LPC, LLC
(Adult Intake)

Name: _____
(LAST) (FIRST) (M.I.)

Address: _____
(STREET AND NUMBER)

_____
(CITY, STATE, ZIP)

DOB: _____/_____/_____ Age: _____

Cell Phone: (_____)_____ May I leave a message: _____

Home/other Phone: (_____)_____ May I leave a message: _____

Email: _____
*Please note by leaving your email address you are giving permission for email appointment reminders.

Emergency Contact:
Name: _____
Phone: _____
Relation: _____

Please provide the following information for my records. Leave blank any question you would rather not answer, or would prefer to discuss with me in person. Information you provide here is held to the same standards of confidentiality as our therapy.

TREATMENT HISTORY:

Have you received mental health services in the past (ex: outpatient therapy, marriage counseling, psychiatric services): YES NO

If yes, please list therapist name/type of service/approximate dates:
_____
_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)? YES NO

If yes, please list:

_____

_____

Prescribed by: _____

HEALTH AND SOCIAL INFORMATION:

Do you currently have a primary physician? YES NO

If yes, who is it? _____

How would you rate your current physical health?

( )Poor ( )Unsatisfactory ( )Satisfactory ( )Good ( )Very Good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.:

_____

_____

Are you currently on medication to manage a physical health concern? If yes, please list: _____

Are you having any problems with your sleep habits? YES NO
If yes, check where applicable:

( ) Sleeping too little ( ) Sleeping too much ( ) Poor quality sleep
( ) Disturbing dreams ( ) other _____

How many times per week do you exercise? _____

Are you having any difficulty with appetite or eating habits? YES NO
If yes, check where applicable: ( ) Eating less ( ) Eating more
( ) Bingeing ( ) Restricting

How often do you drink alcohol?
( ) daily ( ) weekly ( ) monthly ( ) rarely ( ) never

How often do you engage in recreational drug use?
( ) daily ( ) weekly ( ) monthly ( ) rarely ( ) never

Have you had suicidal thoughts recently?
( ) frequently ( ) sometimes ( ) rarely ( ) never

Have you had suicidal thoughts in the past?
( ) frequently ( ) sometimes ( ) rarely ( ) never

Have you ever experienced any of the following?

Extreme depressed mood	Yes / No
Dramatic mood swings	Yes / No
Rapid speech	Yes / No
Extreme anxiety	Yes / No
Panic attacks	Yes / No
Phobias	Yes / No
Sleep disturbances	Yes / No
Hallucinations	Yes / No
Unexplained losses of time	Yes / No
Unexplained memory lapses	Yes / No
Alcohol/substance abuse	Yes / No
Frequent body complaints	Yes / No
Eating disorder	Yes / No
Body image problems	Yes / No
Repetitive thoughts (e.g. obsessions)	Yes / No
Repetitive behaviors (e.g. frequent checking, hand washing)	Yes / No
Suicidal attempts	Yes / No If yes, when?

Were you abused as a child? YES NO
If yes, please check all that apply:
( ) Verbal ( ) Physical ( ) Emotional ( ) Sexual

Are you currently in a romantic relationship? YES NO

On a scale of 1-10 (10 being the highest quality), how would you rate your current relationship? _____

In the last year, have you experienced any significant life changes or stressors? If yes, please explain: _____
_____
_____
_____

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling, parent, uncle, etc.)

Difficulty	**Yes / No**	**Family member**
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	Yes / No	
Panic attacks	Yes / No	
Schizophrenia	Yes / No	
Alcohol/substance abuse	Yes / No	
Eating disorders	Yes / No	
Trauma history	Yes / No	
Suicide attempts	Yes / No	
Obsessive Compulsive Disorder	Yes / No	

OCCUPATIONAL INFORMATION:

Are you currently employed? YES NO
If yes, who is your current employer/position?
_____

Do you enjoy your work? YES NO
Do you find your job to be highly stressful? YES NO

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious or spiritual? YES NO

If yes, what is your faith? _____

Other Information:

Are you currently involved in any active legal cases (traffic, criminal, civil, custodial)? YES NO

If yes, please describe: _____
_____

Have you ever been convicted of a crime (including DUI)? YES NO
If yes, please describe: _____
_____

Are you currently on probation or parole? YES NO

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

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

What are your goals for therapy? _____
_____
_____
_____
_____
_____

Please share any other information you would like the therapist to know:
_____
_____
_____
_____
_____