LANTERN PSYCHOLOGY

Client Intake Information

Name: Preferred Name:

Date: Date of Birth: Age:

Street Address:

City, State, Zip code:

Phone number: OK to leave Voice Message? Yes No

E-mail address: OK to send email? Yes No

Emergency contact: Phone Number:

Relationship to emergency contact:

Are you currently under guardianship or conservatorship? Yes No

If so, who is the guardian? Phone #:

Who do you live with?

Are you currently employed? Yes No For how long:

Position:

Preferred language: Racial/ethnic identity:

Sex assigned at birth: Male Female Intersex/Born with DSD

Gender: Man Woman Transgender Genderqueer Something Else

Sexual Orientation: Bisexual Gay/Lesbian Heterosexual Queer Pan/Omni

Questioning Prefer not to answer Something Else

Relationship Status: Single Married Partnered Divorced Separated

Who referred you to Lantern Psychology? _____

Current treatment providers:

Name	Provider type	E-mail	Phone/fax#
1.			
2.			
3.			
4.			
5.			

Describe briefly your family and current primary relationships:

Name	**Age**	**Relationship**	**How do you get along?**
1.			
2.			
3.			
4.			
5.			

What brings you in now?

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Please rate each of the following concerns as they apply to you at the **present time** on a scale of 1-5 (1 = not a problem/no concern; 3 = somewhat a concern/problem; 5 = very strong/severe concern). **Make the best estimate you can.** Circle your response.

Feelings of sadness, crying, being "down"	1	2	3	4	5
My mind feels like its racing	1	2	3	4	5
Unwanted thoughts in my mind	1	2	3	4	5
Sometimes I can't control what I do	1	2	3	4	5
Sleep problems	1	2	3	4	5
Feeling worthless	1	2	3	4	5
Problems with anger/temper	1	2	3	4	5
Feeling like things aren't real	1	2	3	4	5
Problems with my eating	1	2	3	4	5
There are things too painful to talk about	1	2	3	4	5
Concerns about my sexuality	1	2	3	4	5
Use of alcohol and/or drugs	1	2	3	4	5
Doing things over and over	1	2	3	4	5
Seeing or hearing things that others don't	1	2	3	4	5
Feeling anxious/nervous	1	2	3	4	5
Being close to people	1	2	3	4	5
Spiritual concerns	1	2	3	4	5
Pain and/or health concerns	1	2	3	4	5

When was your last physical?

Are you currently taking any medications or under any medical treatment? Yes No

Medication/Treatment	Dates	Prescribing Physician

Explanation of any current medical issues:

Have you ever been hospitalized for mental health reasons? Yes No

If so please provide the following information to the best of your ability:

Hospital Name Dates Reason Medications prescribed

Have you ever been in psychiatric or mental health treatment? Yes No

If so please provide the following information to the best of your ability:

Location Dates Reason

Please feel free to add any additional information below that would be important for us to be aware of at this time. During your initial assessment, you will have time and opportunity to go into more detail if you prefer sharing then instead.