(512) 638-1917
LitschiTherapy.com

# Litschi Therapy PLLC

## INTAKE FORM

Name: _____ Date of Birth: _____ Age: _____

Address: _____ Gender: _____

City: _____ State: _____ Zip_____ May I mail to this address? ☐ Yes ☐ No

Telephone: _____ (cell) - ok to leave message? ☐ Yes ☐ No

_____ (work) - ok to leave message? ☐ Yes ☐ No

_____ (home) - ok to leave message? ☐ Yes ☐ No

Email: _____ May I email you? ☐ Yes ☐ No

How were you referred to me? _____

Ethnic background: _____ Religion/Spirituality: _____

Relationship status: _____ Name and age of partner:_____

Current household members:

| Name: | Age: | Relationship: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| Children living outside of home: | | |
| | | |
| | | |

Who to call in case of emergency: _____ Relationship: _____

Telephone(s): _____

Your Occupation:_____ If currently employed for how long:_____

Describe current job satisfaction: _____

_____

If student, where: _____Program/Major: _____

Highest level of education: _____

(512) 638-1917
LitschiTherapy.com

Primary Physician: _____ Phone: _____

List any current psychotropic medications: _____

Any hospitalizations? (dates and reasons): _____

_____

Name of previous counselor(s) and dates: _____

_____

Issues focused on: _____

_____

*Please scale from 1-5 (5 being very concerned) if any of the following concerns pertain to you:*

___ Depression
___ Self-Esteem
___ Anxiety
___ Work/Stress
___ Eating Concerns and Body Image
___ Fears/Phobias
___ Obsessions/Compulsive behaviors
___ Finances
___ Insomnia
___ Unhappiness
___ Spiritual Concerns
___ Emotional Instability
___ Other: _____

___ Separation/Divorce
___ Self-Inflicted Harm/Cutting
___ Relationships
___ Anger
___ Sexual Problems
___ Career Choices
___ Self-Control
___ Suicidal Thoughts
___ Health Problems
___ Panic Attacks
___ Grief/Loss
___ Legal Problems

Do you currently drink alcohol? ☐ Yes ☑ No

How much/how often: _____

Do you currently use other drugs? ☐ Yes ☑ No

What type/how often: _____

How do you scale your relationship with alcohol or drugs from 0-5? (0 being "not concerned at all," and 5 being "very concerned") _____

Are there desirable or undesirable results of your drug or alcohol use? (low school or job performance, physical problems, relationship stress, DWI's?) ☐ Yes ☐ No Please explain:

_____

Have you considered suicide? ☐ Yes ☐ No
Have you attempted suicide? ☐ Yes ☐ No If yes to either, please explain:

How is your physical health? Chronic pain? Ongoing issues?

Examples of exercise routine, creative outlets, self-care activities you enjoy:

Briefly describe experiences of trauma (physical and psychological):

What are your goals or what would you like therapy to support you with?

Anything else you think it is important to mention?