**LightSource Counseling, Inc.**

**Lisa Ferguson**

LCAC CSAT CADACII CCPS, EMDR Trained Therapist

Licensed Clinical Addictions Counselor

Certified Sex Addiction Therapist

Certified Clinical Partner Specialist

8000 West River Road

Yorktown, IN 47396

INTAKE FORM:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_ Phone 2:\_\_\_\_\_\_\_\_\_\_\_\_

E mail address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact/ phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship status: married\_\_\_\_( years \_\_\_\_) never married\_\_\_\_ separated\_\_ in a relationship\_\_\_

 Divorced\_\_\_\_(years\_\_\_) widowed\_\_\_(years\_\_\_)

Children's names and ages:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen a counselor before? If so, where and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current reason for seeking counseling:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Designated family physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last visit to family physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last comprehensive physical:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke or have you ever had a smoking habit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Confidential health information questionnaire**:

Please check any of the following for which you have received medical care:

Allergies\_\_\_ irritable bowel\_\_\_ epilepsy/seizures\_\_\_ vision problems\_\_\_ blood pressure\_\_\_ headaches\_\_\_ diabetes\_\_\_ emotional problems\_\_\_ stomach problems\_\_\_ head injury\_\_\_ heart disease\_\_\_ sleep problems\_\_\_ arthritis\_\_\_cancer\_\_\_asthma\_\_\_ chronic pain\_\_\_ hearing problems\_\_\_

Please list any hospitalization dates and reasons:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Currently under the care of a physician?\_\_\_ If so, for what?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current medications?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any past medication for pain, nervousness, depression? (please list)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever abused any of the above mentioned medications?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any prior mental health services received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check in the area where you think you have a problem:

Anxiety\_\_\_ nervousness\_\_\_ behavioral problems\_\_\_ parenting\_\_\_ physical health\_\_\_ bills\_\_\_ weight/body image\_\_\_compulsive behavior\_\_\_dental health\_\_\_ depression\_\_\_ sleep\_\_\_ reproduction\_\_\_ relationships\_\_\_ self esteem\_\_\_work/academic\_\_\_ ADHD\_\_\_ stress\_\_\_ anger\_\_\_ eating/ nutrition\_\_\_alcohol/other drugs\_\_\_

Briefly describe your:

Eating habits:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

sleep/rest:

use of alcohol/other drugs:

caffeine intake:

smoking:

physical exercise:

hobbies/play:

Please describe any medical concerns not listed above that you believe relevant:

***Current Living Situation***

What is your living arrangement? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(i.e. independent/family setting, etc.)

With whom do you live? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long in your current living situation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this the person(s) you are closest to? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If not, who are you closest to? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does this person abuse drugs and/or alcohol? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been abused in your current living situation? ( If yes please indicate verbal, emotional, sexual, physical in the space below and characterize briefly)

Have you ever been abused (see above) **prior to** your current living situation? ( If yes please indicate verbal, emotional, sexual, physical in the space below and characterize briefly)

***Partner/Relationships History***

List any long term/intimate and/or marital relationships.

Name/Dates of Relationship: Reasons Relationship Ended:

|  |  |
| --- | --- |
| 1. (Current) |  |
| 2. |  |
| 3. |  |
| 4. |  |

List any children you have or live with.

Name: Age/ Relationship With whom do they live

 (good,fair, poor,none)

|  |  |  |
| --- | --- | --- |
| 1.  |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |

Are you actively involved with the child/children? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Family of Origin***

As far as you know, were your mother’s pregnancy and your birth normal? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where were you born? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Raised? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List the people you lived with during childhood and/or regard as your family of origin.

(Include parents/step-parents/brothers/sisters, etc.)

Describe Relations:

Relationship: Name: Age: Living: (good/fair/poor/none)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| 4. |  |  |  |  |
| 5. |  |  |  |  |
| 6. |  |  |  |  |
| 7. |  |  |  |  |

Any history of alcohol/drug/pornography use/abuse/dependence or abusive behaviors in the above mentioned individuals? Has anyone of these individuals had a history of suicidality?

**Have you ever had recurring suicidal thoughts, or any suicide attempts or cutting/self harm?**

If so, when was the most recent? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please explain:

Have you had any mental health diagnoses? If so, please list:

Please list three qualities that you like about yourself:

Please list three qualities that you would like to change about yourself:

Please list your three greatest problems and numbered from greatest to least:

***CANCELLATION POLICY:***

***The time I set aside for your appointment is very important to me. I take it seriously and dedicate myself to focus on you, listen well, and present my best counsel. I often postpone meeting with new clients in order to give existing ones the time and care they need. Therefore please notify me via phone or e mail [ (765 )276-0407*** ***lightsourcecounseling@gmail.com******, at least 48 hours in advance for cancellation of a session. In the absence of this timely notification, you will be charged my hourly rate for the session missed.***

Please sign if you agree with the following statement:

“I have read and agree to abide by the cancellation policy for LightSource Counseling, Inc., and I consent to allow Lisa Ferguson of LightSource Counseling, Inc. to render to me psychological counseling services.”

Client signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_