LightSource Counseling, Inc.

Lisa Ferguson

LCAC CSAT CADACII CCPS, EMDR (EMDRIA) Certified 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 (good,fair, poor,none)	With whom do they live
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.)

Relationship:	Name:	Age:	Living:	Describe Relations: (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:_____