

Get Back To Being You, P.C.
Christy Lindquist, LCPC
Intake Data Sheet
Psychotherapy and Consultation

General Information	
Name _____	
Address _____	
Home Phone _____	Cell Phone _____
Preferred number for contact _____	Ok to leave a message? _____
Date of Birth _____	Your age today _____ Sex _____
Were you referred to me? _____	
If yes, who referred you? _____	
If no, how did you hear about me? _____	
Occupation _____	
Education Level _____	

Family	
Marital Status _____	
Spouse/Partner _____	His/her occupation _____
Children (name, age, sex) _____	

Is your father living? _____	Where? _____ Date of Death? _____

His occupation _____	
What is/was your relationship with your father like? _____	

Is your mother living? _____	Where? _____ Date of Death? _____

Her occupation _____	
What is/was your relationship with your mother like? _____	

Siblings/Other Important People _____	

Recent changes in your life or those close to you (marriages, deaths, job changes, divorces, moves, serious illness) _____	

Medical	
Family Physician _____	Address _____
Significant illnesses, injuries, physical conditions, hospitalizations, etc (give dates) _____	

Medications/Drugs now used _____	

Previous counselors _____	

Interests

Problems/Concerns

Please mark any specific problems or concerns and use the spaces provided to specify if necessary.

- | | |
|---|--|
| <input type="checkbox"/> Abuse Survivor Issues | <input type="checkbox"/> Inadequacy |
| <input type="checkbox"/> Abandonment and/or Fear of | <input type="checkbox"/> Infidelity / Affair Recovery |
| <input type="checkbox"/> Adjusting to Change / Life Transitions | <input type="checkbox"/> Isolation (Emotional & Social) |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Life Purpose/Meaning/Inner-Guidance |
| <input type="checkbox"/> Attachment Issues | <input type="checkbox"/> Mood Disturbance |
| <input type="checkbox"/> Bereavement | <input type="checkbox"/> Mood Swings |
| <input type="checkbox"/> Bipolar | <input type="checkbox"/> Obsessions |
| <input type="checkbox"/> Blended Family Issues | <input type="checkbox"/> Oppositional & Defiant Behavior |
| <input type="checkbox"/> Child and/or Adolescent Issues | <input type="checkbox"/> Panic |
| <input type="checkbox"/> Communication Problems | <input type="checkbox"/> Phobias / Fears |
| <input type="checkbox"/> Compulsions | <input type="checkbox"/> Physical Abuse |
| <input type="checkbox"/> Control Issues | <input type="checkbox"/> Post Traumatic Stress |
| <input type="checkbox"/> Creative Blocks | <input type="checkbox"/> Relationships & Marriage |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Self-Care |
| <input type="checkbox"/> Developmental Disorders (Autism,
Aspergers, etc.) | <input type="checkbox"/> Self-Doubt |
| <input type="checkbox"/> Dissociation | <input type="checkbox"/> Self-Esteem |
| <input type="checkbox"/> Divorce / Divorce Adjustment | <input type="checkbox"/> Self-Harm (Cutting, etc.) |
| <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Sensitivity to Criticism |
| <input type="checkbox"/> Eating & Food Issues | <input type="checkbox"/> Sexual Abuse |
| <input type="checkbox"/> Emptiness | <input type="checkbox"/> Shame |
| <input type="checkbox"/> Emotional Abuse | <input type="checkbox"/> Social Phobia/Anxiety |
| <input type="checkbox"/> Emotional Overwhelm | <input type="checkbox"/> Stress |
| <input type="checkbox"/> End-of-life Adjustment | <input type="checkbox"/> Suicidal (Thoughts, Feelings, and
Behaviors) |
| <input type="checkbox"/> Family Problems | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Family of Origin Issues | <input type="checkbox"/> Trust Issues |
| <input type="checkbox"/> Grief & Loss | <input type="checkbox"/> Violence |
| <input type="checkbox"/> Habits | <input type="checkbox"/> Women's Issues |
| <input type="checkbox"/> Impulsivity | |

Other problems/concerns: _____

<p>Emergency Contact Information</p> <p>Name: _____</p> <p>Address: _____</p> <p>Phone: _____ Relationship to you: _____</p>

Insurance Information

Policy Holder's Name: _____ DOB: _____
Relationship to you: _____
Insurance Company Name: _____
ID# _____ Group # _____
Deductible: \$ _____ Has it been met? _____
Copayment (amount *not* covered by your insurance for each visit): \$ _____
Who will pay noninsured balance? _____
If you are required to get preauthorization, have you done so? _____ # visits authorized: _____
Authorization # _____
Other Insurance
Spouse's Insurance (if any): Name of Plan: _____
Spouse's DOB: _____ Contract #: _____ Group #: _____
Other Insurance Type: _____
Deductible: \$ _____ Has it been met? _____
Copayment (amount *not* covered by your insurance for each visit): \$ _____

In this box, please indicate the address and telephone number you want me to use to when sending bills or when I need to contact you. If this box is left blank, I will use the address and any of the telephone numbers you have provided above.

If you do *not* want me to leave a message on your voice mail, please tell me how you want me to reach you by phone:

Signature _____ **Date** _____