

HILARY SHAW, MA MS LDN RD
INTAKE FORM

NAME: _____ MARITAL STATUS: _____ DATE: _____
ADDRESS: _____

PHONE: (hm) _____ (wk) _____ (cell) _____

DATE OF BIRTH: _____

OCCUPATION: Self: _____ Spouse _____
(Employer): _____

MEDICAL CONDITIONS: (Please include any medications currently taking, amount,
purpose, and who prescribed them) _____

Primary Care Physician: _____ Date of last visit _____

PREVIOUS PERSONAL COUNSELING : YES // NO (If yes, please list names and
dates)

PRESENTING CONCERN (What is the reason for seeking help now? Other concerns?

When did concern begin? _____
What are your symptoms (crying, not eating, cant get off your mind, etc.)

How often does concern occur (hourly, daily, weekly, etc) _____
When and where and with whom?

With regard to this concern, how do you feel emotionally?

Physically? _____

What thoughts go through your mind when you think about this issue?

How have you dealt with this concern prior to coming here?

FAMILY HISTORY : Describe any major changes that have occurred to you or your family in the last year (if relevant, in the past few years):

CHILDREN: NO // YES Number of biological _____ Step _____

Referred by: _____

Below is a list of problems people sometimes have. Take each of these problems and decide how much each one is presently of distress, worry, or bother to you.

Circle only ONE number for each problem.

USE THE FOLLOWING SCALE WITH 1 = NOT AT ALL AND 5 = EXTREME

Not at all	slight	moderate	considerate	extreme	
1	2	3	4	5	
1. Feeling angry at others?.....	1	2	3	4	5
2. Being timid or shy?.....	1	2	3	4	5
3. Feeling depressed, dejected?.....	1	2	3	4	5
4. Being easily embarrassed?.....	1	2	3	4	5
5. Feeling like a failure?.....	1	2	3	4	5
6. Feeling on the verge of tears.....	1	2	3	4	5
7. Being ill at ease with others?.....	1	2	3	4	5
8. Being discouraged?.....	1	2	3	4	5
9. Not feeling like eating?.....	1	2	3	4	5
10. A lack of real friends?.....	1	2	3	4	5
11. Feeling shy with the opposite sex?.....	1	2	3	4	5
12. Blame, criticize or condemn others?.....	1	2	3	4	5
13. Trouble keeping conversation going?.....	1	2	3	4	5
14. Feeling hopeless?.....	1	2	3	4	5
15. Headaches?.....	1	2	3	4	5
16. Feeling things around you are unreal?.....	1	2	3	4	5
17. Difficulty with sleep?	1	2	3	4	5
18. Stay by yourself a lot?.....	1	2	3	4	5
19. Feeling tense and nervous?.....	1	2	3	4	5
20. Upset stomach?.....	1	2	3	4	5
21. Sexual problems?.....	1	2	3	4	5
22. Suicidal thoughts?.....	1	2	3	4	5
23. Problems with family?.....	1	2	3	4	5
24. Feeling alienated?.....	1	2	3	4	5
25. Drug/Alcohol use?.....	1	2	3	4	5
26. Problems with spouse or special friend?.....	1	2	3	4	5
27. Stress related to _____ (If not covered above)?.....	1	2	3	4	5
28. Anxiety related to _____ (If not covered above)?.....	1	2	3	4	5
29. Being overweight or underweight (circle one)?	1	2	3	4	5
30. Other? _____	1	2	3	4	5