Susan M Beglinger

M.S., LMFT, LCADC, AAMFT Approved Supervisor

Therapy for Individuals, Couples, & Families

Counseling Intake & Insurance Form

To help me with our first session, please fill out as completely and clearly as possible.

Date_____ Referral Source_____

Full Name_____

Male Female Ethnic Origin_____

Email Address_____@_____

Address_____,_____
Street City State Zip

Phone_____/_____/_____
Home Work Cell

Please indicate if voice message cannot be left*

Date of Birth_____Age_____SS#_____/_____/_____

Occupation_____ Highest Level of Education Achieved_____

Employment: *full-time* *part-time* *unemployed* *homemaker* *student*

Place of Birth_____

Religious Affiliation_____ *Practice* *Inactive*

Marital Status: *Single* *Married* *Separated* *Divorced* *Other*

If married or living in a permanent relationship, how long?_____

Spouse or Partner's name_____

Sexual Orientation_____

Military Service_____When_____Branch_____Combat_____

Children

Name _____ Age_____ Name _____Age_____

Name _____ Age_____ Name _____Age_____

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Why are you here to see me?

List symptoms:

When did the problem(s) first start?

List any doctors you have seen for this condition.
Please provide a phone number *(no one will be contacted without your permission).*

Please list any medication that you have taken for this current problem.

Medication	Dose	Year?	For How Long?	Did it Work?	Prescribing MD?

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Family History & Major Illnesses

	Name	**Age** If deceased, Age at death	**Occupation** If deceased, cause of death	**Illness & Issues** List all major illness & issues, including psychiatric, neurologic, alcoholism, drug abuse, suicide, suicide attempts, divorces, & relationship issues
Mother				
Father				
Siblings				
Spouse				
Children				
Comments and other pertinent information:				

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Psychiatric Hospitalizations:
Please list any hospitalizations that you have had in the past for psychiatric problems, either similar to current problem or any other:

Hospitalization	Date	Reason	Where?
1st			
2nd			
3rd			

Use other side of this page of any additional hospitalizations

Outpatient Treatment:
Please list any treatment for the following problems:

	Date	Reason	Where?
Mental Health			
Substance Abuse			
Gambling			

Gambling:

	Yes	No
Are you preoccupied with reliving past gambling experiences, or planning the next venture, or thinking of ways to get money to gamble?		
Need to gamble with increasing amounts of money in order to achieve desired excitement?		
Unsuccessful efforts to control, cut back, or stop gambling		
Restless or irritable when attempting to cut down or stop gambling?		
Gambled as a way of escaping from problems or relieving dysphoric mood		
After losing money gambling, returns another day to get even		
Lies to others to conceal the extent of involvement with gambling		
Has committed illegal acts, i.e..bad checks or taken money that didn't belong to you in order to pay for gambling		
Jeopardized or lost a significant relationship, job or education opportunity because of gambling		
Relies on others to provide money to relieve a desperate financial situation caused by gambling		

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Gambling: *(cont)*

Amount of money spent on ambling episodes	
Largest amount of money won?	
Frequency of gambling episodes: __*daily* __*4-5 times/wk* __*2-3 times/wk* __*weekends* __*occasionally*	
How long has gambling been a problem?	
Last gambling episode?	

Alcohol:

How many drinks do you consume in an average day?	
What is the most you have had to drink in a 24 hr period during the last year?	
Frequency of use: __*daily* __*4-5 times/wk* __*2-3 times/wk* __*weekends* __*occasionally*	
Ever been told or felt you should cut down on drinking?	
Number of years used?	
Last use?	
Ever felt bad or guilty about your drinking?	
Ever drink first thing I the morning to steady nerves or get rid of hangover?	

Recent Stressful Life Events:
Check any of the following events that have occurred during the last 2 years

- ☐ Engaged
- ☐ Separated
- ☐ Married
- ☐ Divorced
- ☐ Breakup of important relationship
- ☐ Child left home
- ☐ Death of spouse / partner
- ☐ Bad health/behavior of family member
- ☐ Difficulties with family member
- ☐ Personal injury/illness
- ☐ Retired / lost jobchanged residence
- ☐ Legal difficulties, multiple traffic violations
- ☐ Owe money
- ☐ **NONE OF THE ABOVE**

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Check If you have taken any of the following:

- ☐ Marijuana
- ☐ Heroin / Opiates
- ☐ LSD / Hallucinogens / PCP
- ☐ Xanax, Valium, Ativan
- ☐ Loritab, Oxycotin, Vicodin
- ☐ Amphetamines / Speed
- ☐ Cocaine / Crack
- ☐ Glue, Paint, Gasoline
- ☐ **NONE OF THE ABOVE**

Frequency of use:

- ☐ Daily
- ☐ 3-5 times/wk
- ☐ 1-2 times/wk
- ☐ Occasionally
- ☐ Weekends

Legal Matters:

- ☐ Check if ever convicted of a felony
- ☐ Check if you have a pending law suit

Suicide

- ☐ Check if you have ever thought about suicide
  If "yes", when was the last time?

- ☐ Check if you have ever attempted suicide
  If "yes", when and how?

Violence

- ☐ Check if you have ever thought about hurting someone
  If "yes", when was the last time?

- ☐ Check if you have ever hurt someone else
  If "yes", when was the last time?

- ☐ Check if you have ever thought about hurting someone now

Smoking

- ☐ Chew tobacco
- ☐ Smoke tobacco
- ☐ **NONE OF THE ABOVE**

How much? ___1 ___2 ___3 ___4 _____other

How long? _____years

Caffeine *(cups/day)*

- ☐ Coffee ___1 ___2 ___3 ___more
- ☐ Tea ___1 ___2 ___3 ___more
- ☐ Cola ___1 ___2 ___3 ___more
- ☐ Sensitive to caffeine
- ☐ **NONE OF THE ABOVE**

Weight & Height

What is your current weight in pounds? _____

- ☐ Check if your weight has changed more than 1 pounds during the last 6 months

What is your height in inches? _____

Allergies **___None**

Medical Problems **___None**

Age first occurred	List all past / present medical problems as well as any surgeries or accidents

Females – Menstrual History

Check if your periods are irregular	
How long do your periods last?	days
Heck if your moods, depression, irritability, and/or irrationality change with your periods. If checked, list how?	
Check if you are taking an oral contraceptive If checked, how long?	
How many times have you been pregnant?	
How many miscarriages have you had?	
How many living children?	

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Female – Menopause History

- Currently menopausal
- Post menopausal

Sexual History

Parents' Attitude
- Open
- Healthy
- Conservative
- Never discussed

Sexual Preferences
- Same sex
- Opposite sex
- Both

Males: Difficulties with

- Erections
- Ejaculation
- Partner
- Premature ejaculation
- Lack of interest
- Masturbation
- **NONE OF THE ABOVE**

Females: Difficulties with

- No orgasm
- Painful orgasm
- Partner
- Becoming aroused
- Lack of interest
- Masturbation
- **NONE OF THE ABOVE**

Many of the following questions may not apply to you. Some may sound strange or be difficult to answer. Just do the best you can.

Sadness & Depression:

	Yes	No
Do you go through periods of sadness or depression?		
Does your mood come and go?		
Do these feelings come out of the blue?		
Do they happen in reaction to bad things that happen?		
Does the mood last and last?		
Do you have periods of low energy?		
Eo you have periods of not caring?		
Do you lose interest in everything?		
Do you have periods of slowed activity or restlessness?		
During these moods do you have a change in appetite or gain or lose weight?		
Are you in one of these periods right now?		
Do you feel guilty for things that are not your fault?		
Do you tend to stay alone or mope around?		
Does your depressed mood affect your thinking or concentration?		
Do you cry easily or feel desperate?		

Sleep:

	Yes	No
Any trouble with sleep		
Is falling asleep a problem?		
Do you wake up in the middle of the night or too early in the morning?		
Do you have nightmares?		
Do you need regular naps?		
Do you wake up short of breath or in a panic?		
Do you wake up with headaches?		
Do you feel more tired after waking up than you did going to sleep?		
Do you fall asleep at stop lights?		

Anxiety or Fear:

	Yes	No
Do you ever feel on edge, fearful or anxious?		
Does this feeling affect many parts of your life?		
Does it go on for a few days or is it always there? *Always* *Few days*		
Does the nervousness happen in attacks and just as quickly go away?		
When nervous, do you feel your heart race or miss beats?		
When nervous do you have trouble breathing or swallowing?		
When nervous do you get dizzy or feel unreal?		
When nervous do you feel like you are going to die or go crazy or lose control?		
When nervous do you feel shaky, sweaty, flushed?		

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Do you have unrealistic fears of persons, places, things, situations?		
Do you ever have trouble leaving your house, being in crowds, speaking in public?		
Do you ever have memories that are so real the event feels like it is really happening?		
Do you frequently recall terrible events that happened to you or that you witnessed?		
Do you ever feel like you are numb or outside your body?		
Do you ever feel that things are not real?		

Emotional Well Being:

	Yes	**No**
Do you ever have abnormal movements of your body or face?		
Do they happen in your throat or mouth, such as clearing your throat or sniffing?		
Do your hands shake much of the time?		
Do other parts of your body jerk or twitch uncontrollably?		
Do these things happen only during nervous feelings?		
Do these things happen at night when you are trying to sleep?		
Do you frequently eat more than normal amounts of food at one time?		
Do you ever take laxatives, make yourself throw-up or exercise excessively to keep from gaining weight?		
Has your sexual drive or behavior ever been a concern to you in any way?		
Are you concerned about any sexual habit that you consider unacceptable?		
Do you have blackouts, fits or seizures?		
Have you ever fainted and then wet or soiled your clothes?		
Do you ever smell things that no one else smells, such as burnt rubber, urine, feces or old socks?		
Do you ever hear or see things that other people do not see or hear?		
Do you often have headaches?		
Do you frequently get lost or have problems with your memory?		
Do you ever have the sense that walls were "breathing" or objects were changing size?		
Do you have thoughts that just won't go away?		
Do you do things over and over again almost unable to stop?		
If you try to control these behaviors, do you become uncomfortable or anxious?		
Do you ever have urges such as checking your body, locking the door over and over again, washing, counting or having to have everything "just so"?		
Would you or others describe you as rigid?		
Do you take things very seriously to the point that you have rituals or routines or habits that don't seem to make any sense?		
Do you treat others very poorly?		
Do you act unusually rude, hostile or argumentative?		
Do you feel shame or regret later?		

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Have you ever done things out of character such as:

	Yes	No
Gone several nights without sleep?		
Spent a lot of money?		
Used excessive amounts of drugs or alcohol?		
Given away things that you treasure?		
Feel lots of energy or powerful, exceptional, superior?		
Act or feel incredibly strong or smart?		
Do you ever feel extremely jealous?		
Have you ever stopped taking care of yourself, such as bathing, shaving, getting dressed?		
Do bizarre things ever happen to you, such as hearing voices swearing or talking?		
Has the radio or TV ever talked to you or have you ever thought that some part of the program was meant especially for you?		
Have you ever had thoughts or beliefs that others found irrational or hard to believe?		
Do you seem to have more than a normal number of medical illnesses or conditions?		
When you were growing up, did you witness or experience physical abuse from caretakers?		
Have you ever been sexually abused?		

Please circle any of the following terms that describe you when you were growing up:

Selfish	Stealing	Inattentive
Defiant	Hurt Animals	Fidgety
Set Fires	Destructive	Anti-authority
Lack Conscience	Lying	Fighting
Arguing	Distractible	Risky Behaviors
Willful	Restless	Irresponsible
Call out in class	Abusive	Can't wait turn
Bully	Cheating	Disrespectful
Short attention	Impulsive	Hateful
Whining	Demanding	Uncaring
Sickly	Sad	Anxious

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Insurance

If not using insurance, please skip this portion and initial here:_____

Insurance Policy Holder:

- ☐ Self
- ☐ Spouse
- ☐ Other

Place of employment_____ Job Title_____

Insurance Provider_____

Insurance Address_____

If other than self, provid birth date _____ & SS# _____of insured

Insurance Release:

I, _____, hereby
Patients / Guardian Name

Authorize Susan M. Beglinger to release information to my insurance provider regarding,

_____
Patients Name

I authorize my insurance provider to:

_____Remit payment to Susan M. Beglinger, Ltd

_____Remit payment to insured

_____I will not be using insurance

_____ _____
Patient / Guardian Signature Date

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