Lorrie G. Beevers, PhD
679 Emory Valley Rd. - Suite B
Oak Ridge, TN 37830

Initial Intake: Part II

Home Phone:_____ May we leave a message? ____Yes ____No
Cell Phone:_____ May we leave a message? ____Yes ____No
Work Phone:_____ May we leave a message? ____Yes ____No

Have you previously been in any type of psychotherapy or counseling in the past? If so with whom and approximately when and for how long:

_____
_____

Are you currently taking prescription (including psychiatric) medications? If so please list medications:

_____
_____
_____
_____

GENERAL PHYSICAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (Please circle)
Poor Unsatisfactory Satisfactory Good Very good Excellent
Please list any specific health problems you are currently experiencing:

_____
_____
_____

2. How would you rate your current sleeping habits? (Please circle)
Poor Unsatisfactory Satisfactory Good Very good Excellent
Please list any specific sleep problems you are currently experiencing:

_____
_____

3. How many times per week do you generally exercise? _____
What types of exercise to you participate in?

_____
_____

4. Please list any difficulties/problems/issues you experience with your appetite or eating patterns:

_____
_____
_____

5. Are you currently experiencing: Depression_____
Anxiety: _____
If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias? _____
If yes, when did you begin experiencing this? _____ _____

7. Are you currently experiencing any chronic pain? _____ No _____ Yes
If yes, please describe:
_____
_____

8. Do you drink alcohol: _____ Yes _____ No
If yes, please describe your pattern of alcohol use:
_____
_____

10. Are you currently married or in a romantic relationship? _____ Yes _____ No
If yes, for how long? _____
On a scale of 1-10, how would you rate your satisfaction in your relationship? (1 being a low level of satisfaction and 10 being very satisfied in the relationship): _____

11. Have you experienced significant life changes or stressful events in your life: If so, please briefly describe:
_____
_____
_____

FAMILY MENTAL HEALTH HISTORY:
In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member(s) relationship to you in the space provided (father, mother, grandmother, uncle, etc.)

Alcohol/Substance Abuse: ____ Yes _____No _____
Anxiety: _____ Yes _____ No _____
Depression: _____ Yes _____ No _____
Domestic Violence: _____ Yes _____ No _____
Eating Disorders: _____ Yes _____ No _____
Weight Issues/Obesity: _____ Yes _____ No _____
Obsessive Compulsive Behavior: _____ Yes _____ No _____
Schizophrenia: _____ Yes _____ No _____
Suicide Attempts: _____ Yes _____ No _____

ADDITIONAL INFORMATION:

1. Are you currently employed? _____ Yes _____ No

If yes, what is your current employment situation?

_____

_____

Do you enjoy your work? Is there anything particularly unpleasant or stressful about your current work?

_____

_____

_____

2. What do you consider to be some of your strengths?

_____

_____

_____

4. What do you consider to be some of your weaknesses?

_____

_____

_____

5. What brings you to therapy now and what would you like to accomplish in your therapeutic work?

_____

_____

_____

_____

_____

_____

_____