Lynne M. Treibel, LISW
Emotional Nourishment.

A. Indentification:

Name: ________________________ Today's Date:__________ DOB:__________

Marital Status: _______ Gender Identity: __________ Age: ___ Social Security #:______________

Home Address:______________________________ City:________________

State: ____ Zip: ________ Home phone: ____________E-mail: ____________________

Current employment: ________________________ Work phone:______________

Where do you give the office permission to contact you? ❑ Work Phone ❑ Home Phone ❑ Email

Any restrictions for these communications?______________________________

B. Emergency Contact:

Who do you authorize the office to call in case of an emergency?

Name:______________________________ Phone: ____________________

Relationship: __________ Address:______________________________

I authorize Lynne Treibel to contact the above named person in emergency situations, which expires in 1 year from the date of this signature.

____

Signature Date

C. Cultural Identity:

How do you identify religiously, spiritually, or culturally?__________________________

Any spiritual or cultural needs that need to be addressed in therapy treatment?______________

How important are spiritual concerns in your life?__________________________

Ethnicity/National Origin/Race: ______________________________

D. Chief Concerns:

What are the main issues that brought you here?

____

____

E. Frequency of Concerns:

How often do you experience the main issues that brought you here (# times per week, etc)?

____

F. Intense Emotions:

Any difficulty controlling intense emotions? ❑ No ❑ Yes

If yes, describe the frequency (# times per week,etc.): __________________________

G. Trauma & Abuse:

Client name:
DOB:

Any past or current trauma or abuse experiences? ❑ No ❑ Yes

If yes, describe if able:____

H. Suicidality and Homicidality:

Have you ever thought of killing or harming yourself or others? ❑ No ❑ Yes

If yes, describe the thought(s): ____

If yes, describe the frequency and date of last occurrence:_________________________________

Are you currently thinking of killing or harming yourself or others? ❑ No ❑ Yes*

*If yes, STOP. Go to the emergency room or call 911 now. Outpatient care is inappropriate for you.

I. Past Treatment:

List past counseling, psychiatric, or drug or alcohol treatment(s) with approximate year. Did it work?____

Have you been hospitalized for psychological reasons? ❑ No ❑ Yes

If yes: For what reason? When? For how long? With what results?

____

J. Family of Origin:

Briefly describe your relationship(s) with the family members with whom you were raised.

____

____

Briefly describe any family history that is relevant to your psychotherapy treatment issues.

____

K. Current Family:

Briefly describe your relationship(s) with your current family (spouse, children, etc.) List their ages.

____

____

____

L. Past spouse(s) or partner(s).

Briefly describe any past spousal or long-term relationships, and list any resulting children.

____

____

M. Chemical Use:

What is/are your current drug(s) of choice? Check one or more, as applicable.

❑ Caffiene (sodas, energy drinks, caffiene pills) ❑ Tobacco ❑ Heroin (Or other opiates)

Client name:
DOB:

❑ Methamphetamine (Meth/Speed) ❑ Cocaine ❑ Alcohol ❑ Marijuana (or Hashish, "Spice")

❑ Paint (or other huffing solutions) ❑ Other drug not listed (specify)____________________ ❑ N/A

Describe the method(s) of intake, the frequency (# times per week, etc), and amount:

____

Do you ever feel guilty or defensive about your current substance use? ❑ No ❑ Yes

Does your current substance use interfere with your job, relationship(s) or life? ❑ No ❑ Yes

If yes, describe:____

Any past substance use that interfered with your job, relationship(s), or life? ❑ No ❑ Yes

If yes, describe substance(s) and method of use:______________________________________

N. Legal Issues:

Are you in any way court-ordered or otherwise required to be in counseling? ❑ No ❑ Yes

If yes, describe: ____

Describe any current or past legal issues (CYFD involvement, criminal charges, probation, lawsuits, etc): ____

I have a current: ❑ Probation/Parole Officer ❑ Attorney ❑ Other Legal Representative ❑ N/A

Who is legally able to make healthcare decisions for you? ❑ I do. ❑ Guardian/Parent (if under 18)

❑ Power of Attorney ❑ Treatment Guardian ❑ Other (specify)______________________________

O. Education:

List your highest level of educational achievement and year. ______________________________

P. Military service:

Describe any military service and whether you were deployed. ______________________________

Did you ever incur a head injury or severe blow to the head during your service? ❑ No ❑ Yes

Q. Employment:

What do you do for a living? Do you enjoy your work? ____________________________________

R. Medical History:

List any hospitalizations, head injuries, diseases, accidents, injuries, convulsions/seizures, medical conditions, physical problems, health risks, allergies, adverse drug reactions, or sensitivities that impact your emotional or physical functioning today.

____

List any prescribed, non-prescribed, or over-the-counter: medications, vitamins, herbs, or supplements that you currently take. List dosages, the prescriber, directions for use, number of available refills (if prescription), reason for taking them, and effectiveness:

Client name:
DOB:

List all medical or psychiatric providers that currently treat you, with their contact information.

Do you want the office to contact any of the above practitioners to coordinate care? ❑ No ❑ Yes

If yes, list which one(s):

What information would you authorize me to disclose your providers?

I authorize Lynne Treibel to contact the above practitioners with the above information for the purpose of coordinating care. The authorization expires one year from the date of my signature:

Signature Date

S. Health Habits & Nutrition:

Describe your diet and list any restrictions:

Describe any sleep problems:

Describe your exercise activities with frequency (# times per week):

T. Home Safety:

Do you feel emotionally and physically safe at home? ❑ No ❑ Yes

If not, why?

Who lives with you?

U. Other:

Describe anything else that is important for me to know, which you have not written about above.

Please do not write below this line:

Follow-up by clinician:

Based on the responses above and on ❑ interview data ❑ records I reviewed ❑ other information I have asked the client to complete and/or I have completed the following forms:

❑ Chemical use survey ❑ Suicide risk assessment summary and recommendations

Other Evaluation(s):

Client name:
DOB: