THE THERAPY PLACE OF LA CROSSE, LLC

ADULT INTAKE SCREENING FORM

Name:____Date:____________________

Who referred you to our agency?____

Please describe the reason you are seeking services:

Please list any prior mental health treatment:

Please circle any of the following that apply to you:

Family problems
Social Problems
School/Work Problems
Physical abuse (current or past)
Emotional abuse (current or past)
Thoughts of ending your life
Spirituality/religious concerns
Learning problems

Problems with appetite
Weight Loss or Gain
Others concerned about your eating/weight
Sexual abuse (current or past)
Legal Issues
Thoughts of hurting yourself or others
Feelings of hopelessness
Past suicide attempt(s)

Medical History:
Primary Care Physician:____

Current medications:____

____

AODA
Have you ever felt you should cut down on your drinking? Yes____ No___
Have people annoyed you by criticizing your drinking? Yes ___ No___
Have you ever felt guilty about drinking? Yes____ No___
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?
Yes ___No ___

Patient signature:____**Date:**____________________

Provider signature:____**Date:**____________________