

# Felicia Einhorn, LCSW DCSW LLC

Therapy for individuals, Couples, Families & Groups

---

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF POLICIES AND PRIVACY PRACTICES

---

The undersigned acknowledges receipt of a copy of the currently effective Notice of Mental Health Practitioner's Policies and Privacy Practices. A copy of this signed and dated acknowledgement shall be as effective as the original.

---

Signature

Print Name

Date

If you are the legal representative of the patient, please print the patient's

---

Name

Authority

Thank you. If you have any questions about this form, or the attached notice please contact Felicia Einhorn LCSW.

# Felicia Einhorn, LCSW DCSW LLC

Therapy for individuals, Couples, Families & Groups

## DEMOGRAPHIC INFORMATION

Referred By: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Home Phone#: \_\_\_\_\_ Cell Phone#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Marital Status:  Married  Divorced  Widowed  Single Dates of Marriages: \_\_\_\_\_

### Medical

Internist \_\_\_\_\_ Phone #: \_\_\_\_\_

Psychiatrist \_\_\_\_\_ Phone #: \_\_\_\_\_

Neurologist \_\_\_\_\_ Phone #: \_\_\_\_\_

Pain Management MD \_\_\_\_\_ Phone #: \_\_\_\_\_

\*\*\*PLEASE SEE MEDICATION RECORD PAGE FOR ALL OF THE MEDICATIONS/SUPPLIMENTS  
YOU ARE CURRENTLY TAKING\*\*\*

### Emergency

Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Contact 2: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Contact 3: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_



# Felicia Einhorn, LCSW DCSW LLC

Therapy for individuals, Couples, Families & Groups

## MENTAL HEALTH INTAKE FORM

### PERSONAL INFORMATION

What is your major complaint?

When did this begin?

Have you previously suffered from this complaint?

Previous therapist(s) seen for complaint:

Previous treatment for complaint:

Aggravating factors for complaint:

Relieving Factors:

#### CURRENT SYMPTOMS: (CHECK THAT APPLY)

- |  |  |   |  |   |   |
|--|--|---|--|---|---|
| <input type="checkbox"/> Anxiety       | <input type="checkbox"/> Appetite Issues | <input type="checkbox"/> Avoidance      | <input type="checkbox"/> Crying Spells | <input type="checkbox"/> Depression     | <input type="checkbox"/> Excessive Energy |
| <input type="checkbox"/> Fatigue       | <input type="checkbox"/> Guilt           | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Impulsivity   | <input type="checkbox"/> Irritability   | <input type="checkbox"/> Libido Changes   |
| <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Racing Thoughts | <input type="checkbox"/> Risky Activity | <input type="checkbox"/> Sleep Changes | <input type="checkbox"/> Suspiciousness | <input type="checkbox"/> Loss of Interest |

Do you have thoughts of suicide?

Have you made any suicide attempts?

If so when?

How?

Do you have thoughts of physically hurting anyone?

Who do you think about hurting?

How would you hurt them?

Have you ever physically hurt anyone?

### MEDICAL HISTORY

Previous diagnosis/mental health treatment:

Previously treated by:

Previous medications:

Dates treated:

Describe any neglect you suffered(ing) and by whom?

Trauma suffered and by whom?

Abuse suffered

Have you ever served in the military?

If yes, where?

# Felicia Einhorn, LCSW DCSW LLC

Therapy for individuals, Couples, Families & Groups

## PRESENT SITUATION

Work:  Full-Time  Part-Time  Student  Unemployed  Disabled  Retired

Married  Single  Widowed  Divorced

Prior Marriages? If yes, how many?

How is your relationship with your partner?

Are you sexually active?

Do you have children? Dates of Birth:

How is your relationship with your child(ren)?

List anyone else who lives with you:

Are you a member of a religion/spiritual group?

What is your level of involvement?

Have you been arrested? When and why?

Have you ever tried any of the following? Check that apply.

Alcohol  Tobacco  Marijuana  Hallucinogens (LSD)  Heroin  Methamphetamines  
 Cocaine  Stimulants (Pills)  Ecstasy  Methadone  Tranquilizers  Pain Killers

If yes to any, list frequency/dates of use:

Have you ever abused prescription drugs? If yes, which ones?

Have you ever been treated for drug/alcohol abuse? If yes, when?

For which substances?

Do you smoke cigarettes? If yes, how many per day?

Do you drink caffeinated beverages? If yes, how many per day?

What would you like to get out of this therapy?

# Felicia Einhorn, LCSW DCSW LLC

Therapy for individuals, Couples, Families & Groups

## CHECKLIST OF CONCERNS

Have you ever needed drugs/alcohol to get going in the morning, to function at work or social events, or to cope with withdrawal symptoms?  Yes  No

Please check any relevant concerns.

### THOUGHTS/FEELINGS/MOOD

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Anger/frustration/hostility               | <input type="checkbox"/> Guilt                             | <input type="checkbox"/> Sadness                               |
| <input type="checkbox"/> Anxiety, nervousness                      | <input type="checkbox"/> Hearing things other people don't | <input type="checkbox"/> Seeing things other people don't      |
| <input type="checkbox"/> Attention, concentration, distractibility | <input type="checkbox"/> Homicidal thoughts                | <input type="checkbox"/> Self-centeredness                     |
| <input type="checkbox"/> Confusion                                 | <input type="checkbox"/> Intrusive thoughts                | <input type="checkbox"/> Self-esteem                           |
| <input type="checkbox"/> Depression                                | <input type="checkbox"/> Judgement problems                | <input type="checkbox"/> Shyness                               |
| <input type="checkbox"/> Disliking Others                          | <input type="checkbox"/> Memory difficulties               | <input type="checkbox"/> Spiritual, religious, or moral issues |
| <input type="checkbox"/> Emptiness                                 | <input type="checkbox"/> Negative thoughts                 | <input type="checkbox"/> Stress                                |
| <input type="checkbox"/> Euphoria                                  | <input type="checkbox"/> Obsessive thoughts                | <input type="checkbox"/> Sudden mood changes                   |
| <input type="checkbox"/> Excessive worry                           | <input type="checkbox"/> Oversensitivity to criticism      | <input type="checkbox"/> Suicidal thoughts                     |
| <input type="checkbox"/> Failure                                   | <input type="checkbox"/> Oversensitivity to rejection      | <input type="checkbox"/> Suspiciousness                        |
| <input type="checkbox"/> Fatigue                                   | <input type="checkbox"/> Panic attacks                     | <input type="checkbox"/> Temper problems                       |
| <input type="checkbox"/> Fear                                      | <input type="checkbox"/> Perfectionism                     | <input type="checkbox"/> Thoughts of hurting self or others    |
| <input type="checkbox"/> Grieving (death, loss, divorce, etc.)     |  |  |

### BEHAVIOR

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Aggression, violence                                 | <input type="checkbox"/> Gambling                                | <input type="checkbox"/> Preoccupation with sex      |
| <input type="checkbox"/> Alcohol use  | <input type="checkbox"/> Hyperactivity                           | <input type="checkbox"/> Procrastination             |
| <input type="checkbox"/> Argumentative  | <input type="checkbox"/> Internet problems                       | <input type="checkbox"/> Purging                     |
| <input type="checkbox"/> Avoidant   | <input type="checkbox"/> Irresponsibility                        | <input type="checkbox"/> Self-destruction/sabotaging |
| <input type="checkbox"/> Compulsive behavior/rituals                          | <input type="checkbox"/> Isolation                               | <input type="checkbox"/> Self-neglect                |
| <input type="checkbox"/> Controlling  | <input type="checkbox"/> Legal Problems                          | <input type="checkbox"/> Sexual dysfunction          |
| <input type="checkbox"/> Decreased/lack of sexual interest                    | <input type="checkbox"/> Letting others take advantage of you    | <input type="checkbox"/> Sleep difficulty            |
| <input type="checkbox"/> Dependency   | <input type="checkbox"/> Loss of appetite                        | <input type="checkbox"/> Smoking                     |
| <input type="checkbox"/> Destruction of property                              | <input type="checkbox"/> Loss of interest in what I used to like | <input type="checkbox"/> Stealing                    |
| <input type="checkbox"/> Drug use – prescription,<br>over-the-counter, street | <input type="checkbox"/> Lying                                   | <input type="checkbox"/> Threats                     |
| <input type="checkbox"/> Eating problems                                      | <input type="checkbox"/> Not able to relax                       | <input type="checkbox"/> Weight gain/loss            |
| <input type="checkbox"/> Financial problems, debt                             | <input type="checkbox"/> Overeating                              | <input type="checkbox"/> Withdrawal from others      |
|   | <input type="checkbox"/> Pornography                             |  |

### FAMILY & RELATIONSHIPS

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Affair                            | <input type="checkbox"/> Housework / Chores       | <input type="checkbox"/> Problems with parents        |
| <input type="checkbox"/> Childhood Issues (your childhood) | <input type="checkbox"/> Interpersonal conflicts  | <input type="checkbox"/> Problems with spouse/partner |
| <input type="checkbox"/> Divorce                           | <input type="checkbox"/> Parenting                | <input type="checkbox"/> Separation                   |
| <input type="checkbox"/> Friendships                       | <input type="checkbox"/> Problems with child(ren) |   |

# Felicia Einhorn, LCSW DCSW LLC

Therapy for individuals, Couples, Families & Groups

---

## ABUSE

---

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Abuse of alcohol           | <input type="checkbox"/> Financial abuse           | <input type="checkbox"/> Sexual abuse by another |
| <input type="checkbox"/> Abuse of drugs             | <input type="checkbox"/> Neglect                   | <input type="checkbox"/> Sexual abuse of another |
| <input type="checkbox"/> Emotional abuse by another | <input type="checkbox"/> Physical abuse by another | <input type="checkbox"/> Verbal abuse            |
| <input type="checkbox"/> Emotional abuse of another | <input type="checkbox"/> Physical abuse of another |  |
- 

---

## WORK & SCHOOL

---

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Absenteeism                     | <input type="checkbox"/> Difficulty with supervisor | <input type="checkbox"/> Procrastination |
| <input type="checkbox"/> Career concerns, goals, choices | <input type="checkbox"/> Performance                | <input type="checkbox"/> School problems |
| <input type="checkbox"/> Difficulty with co-workers      | <input type="checkbox"/> Tardiness                  |  |
- 

---

## OTHER CONCERNS

---

I have no problems or concerns bringing me here.

The information requested in this form will be kept confidential.

---