Seattle Christian Counseling

Julie Stroemel, Psy.D.
Professional Counseling and Testing for Individuals & Adolescents
16000 Bothell-Everett Hwy, Suite 285, Mill Creek, WA 98012
425.501.5729

Intake Form for Testing Services

Date__________________

____
Last Name First Name Date of Birth

____
Address City State/ZIP Sex (M/F)

Email Address: ______________________@___________________________

CAN I EMAIL YOU FOR: (CIRCLE ALL THAT APPLY) SCHEDULING SERVICES UPDATES AVAILABLE GROUPS

I typically will not identify myself as a Mental Health Counselor when I call to protect your privacy. Due to a variety of factors, sometimes people are difficult to reach or never receive messages. Please call me again if you do not hear from me. I or my office staff is authorized to contact you as listed below:

Home phone number ________________________ / Can we leave voice mail at this number? Y/N

Cell phone number ________________________ / Can we leave voice mail at this number? Y/N

Office phone number ________________________ / Can we leave voice mail at this number? Y/N

Other phone number ________________________ / Can we leave voice mail at this number? Y/N

Fax Number ________________________

Who I am authorized to communicate with:
Name:____________________________ Relationship:_____________
Name:____________________________ Relationship:_____________

How did you hear about us?

Radio Internet Church Referral

Other __________________________

Who referred you for testing? ______________________

I have signed a release of information for exchange of records with my referring provider: yes / no

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List any physicians or counselors who are currently treating you:

Name/specialty ____
Address ____
____
Phone number ______________________ Fax number ______________________

Name/specialty ____
Address ____
____
Phone number ______________________ Fax number ______________________

Name/specialty ____
Address ____
____
Phone number ______________________ Fax number ______________________

What are your main concerns? ____
____
____

When did these problems first begin? ____

I am (circle one): Right handed Left handed Use both (ambidextrous)

Circle One: Are your problems getting: better worse staying the same

Medical problems / allergies: ____
____
____

History of head injuries, loss of consciousness, concussion or cerebral damage: ______________________
____

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Previous counseling (With whom / When / For what): ____

____

Current medications (prescriptions, over the counter, or herbal):

Medication	Dose	How long?	For what?

Have there been any recent changes in medications (please list)? ______________________________

____

____

____

Coffee: ____ cups per day   Caffeinated soft drinks: ____ 12-oz cans per day

Tobacco: ____ cigarettes per day ____ packs per day _____ chewed (start date & quit date_____-____)

Alcohol: ____ drinks per day ____ drinks per week (start date & quit date_____-______)

Has anyone ever thought you had a problem with alcohol or drugs? ___ Yes ___ No

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Circle all substances that you have used in the last year:

Marijuana
LSD, mushrooms, PCP, etc.
Ecstacy, GHB, Molly, club drugs
Inhalants
Other ___________________
Cocaine, crack
Codeine, Vicodin, percs, heroin, etc.
Benzo's, barbs, pills
Crank, crystal meth, speed
Steroids

Sleep: In an average week, I sleep ___ 7-8 hours nightly ___ More ___ Less

Check all that apply:

_____Move while dreaming
_____ Frequent awakenings
_____ Oversleep
_____ Snoring
_____Fall asleep during the day
_____ Can't get to sleep
_____ Up early
_____ Have nightmares
_____ Do not feel rested
_____ Wake with headache

_____Sleep Apnea (diagnosed)______hours per night you use CPAP or other appliance for sleep apnea

Please check any problem(s) that apply:

Mood and coping

- ☐ Unusual fears
- ☐ High activity level
- ☐ Slowed response
- ☐ Sexual difficulties
- ☐ Destructiveness
- ☐ Aggressiveness
- ☐ Irritability
- ☐ Restlessness
- ☐ Excessive sadness
- ☐ Defiance
- ☐ Self-destructive
- ☐ Immature behavior
- ☐ Stubbornness
- ☐ Eating problems
- ☐ Sleep problems
- ☐ Mood swings
- ☐ Overly compliant
- ☐ Nightmares
- ☐ Suicidal thoughts
- ☐ Easily frustrated

Day to day tasks:

- ☐ Problems using telephone
- ☐ Problems doing shopping
- ☐ Problems preparing meals
- ☐ Problems bathing w/out help
- ☐ Problems grooming w/out help
- ☐ Problems dressing w/out help
- ☐ Problems toileting w/out help
- ☐ Problems preparing meals
- ☐ Problems doing laundry w/out help
- ☐ Problems managing finances and paying bills
- ☐ Problems managing medications w/out help
- ☐ Problems doing household chores
- ☐ Other problems in driving:_____________________

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Relationships/Social Interaction:
□ Relationship/Marital problems
□ Isolated or withdrawn
□ Problems understanding what others are saying
□ Problems saying what I need to say to others
□ Problems with remembering words
□ Problems understanding people on the phone

Problems in driving :
□ Needs help with transportation: ______________________________________
____
□ Problems getting lost
□ Problems with feeling overwhelmed

Cognitive Function
□ General intellectual level
□ Difficulty with planning/organization
□ Difficulty completing an activity
□ Difficulty adapting to changes (rigid)
□ Inability to concentrate
□ Easily distracted
□ Impulsive
□ Difficulty learning or remembering new information
□ Difficulty with comprehension
□ Difficulty with expression
□ Gets lost easily
□ Difficulty with writing
□ Difficulty with reading comprehension
□ Difficulty with eyes not tracking when trying to read
□ Difficulty with mathematics/handling money
□ Periods of confusion/disorientation
□ Slowed thought processes
□ Other ____

Please Check All Physical Symptoms or Changes that Apply:
□ Numbness
□ Weakness
□ Dizziness
□ Balance Problems/Clumsiness/Falls
□ Pain
□ Headache
□ Nausea
□ Hearing or seeing things that are not there:
Describe:____
____
□ Vision problems/color blind/other__________________
□ Hearing problems_______________________________
□ History of Seizures
□ History of Fainting
□ Appetite/Eating Problems____
□ Diminished Sense of Taste or Sense of Smell (circle)
□ Sleep problems: nightmares/movement in sleep/restless legs/sleep apnea/CPAP/other__________

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Education: Highest grade in school completed: ______________________________

# of years of college: _________ other training? ______________________________

List any certificates or degrees obtained

Any history of school/learning problems? ______________________________

____

Have had tutoring assistance or a special learning plan (IEP or 504 plan)? Y / N

If so, please list what grade you were in, age, the subject, and any special accommodations.__________________

____

____

Current job ______________________________ # of years ___________

Prior work history ______________________________

____

____

Partnership History: Currently (circle) Married / In a committed partnership / Single / Widowed
Please list all marriages or long-term partnerships

Year relationship began	Year married?	# of years married / together	Ages of birth children

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Living Situation: (please circle) house / apartment / assisted living / other ___________________

Persons living in your home: Name Age Relationship

Name	Age	Relationship

Childhood issues ____

Are you or have you ever been a victim of domestic violence? __Yes __No __Unsure

Family history of serious illness/neurological disease/emotional disorder: List persons and problems, if known: __

____

____

____

Have you completed testing before?____

If so, what where you tested for?____

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