

# Lynne Logan Ph.D., L.M.F.T.



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I am interested in an appointment in:

Upper St. Clair Office: \_\_\_\_\_ Murrysville Office: \_\_\_\_\_

## C O U N S E L I N G I N T A K E F O R M

Name:	Today's Date:
Date of Birth:	Relationship Status:
Age:	SSN:
# of Dependents:	Gender: M / F
Home/Mobile Phone:	Is it ok to leave a message for you at this number? Y / N
Work Phone:	Is it ok to leave a message for you at this number? Y / N
Email:	Is it ok to email you? Y / N
Mailing Address:	Fax#: Ok to fax you? Y/N
Current Employer:	Position Title:
Current Occupational Status: (i.e., F/T, P/T, self-employed, student, returning to work):	
How Long on this Job:	Do you enjoy your job:
Education Level:	Special Trainings:
Hobbies:	Military Background:
Talents:	
Emergency Contact Name:	
ER Contact Relationship:	Emergency Contact Phone:
How were you referred?	If online, which website?

**Physical Health Data:**

Describe your Physical Health: Excellent: \_\_\_\_ Good: \_\_\_\_ Average \_\_\_\_ Poor \_\_\_\_ Weight: \_\_\_\_ Height: \_\_\_\_

Are you now under a doctor's care? \_\_\_\_ If yes, name of doctor \_\_\_\_\_

Reason for doctor's care \_\_\_\_\_

List current medications and reason for taking \_\_\_\_\_

Hospitalizations and Reasons: \_\_\_\_\_  
\_\_\_\_\_

Have you ever been hospitalized for a mental illness? \_\_\_\_ Describe \_\_\_\_\_

Have you ever suffered from an eating disorder, such as bulimia, anorexia or obesity? \_\_\_\_\_

Recent major illnesses or surgeries \_\_\_\_\_

**Family Data:**

Where born \_\_\_\_\_ Ethnic ID \_\_\_\_\_

FATHER: age now if living: \_\_\_\_ Age at Death \_\_\_\_ Cause: \_\_\_\_ Your age then: \_\_\_\_

MOTHER: age now if living \_\_\_\_ Age at Death \_\_\_\_ Cause: \_\_\_\_ Your age then: \_\_\_\_

Do your parents live together? Yes \_\_\_\_ No \_\_\_\_ Were Parents Divorced? Yes \_\_\_\_ No \_\_\_\_

Do you feel closest to your Mother \_\_\_\_ Father \_\_\_\_ Neither \_\_\_\_

Your Marital Status \_\_\_\_ #of marriages \_\_\_\_ Spouse's Name \_\_\_\_\_

Living with a partner \_\_\_\_ How long \_\_\_\_ Partner's Name \_\_\_\_\_

CHILDREN: #1 M F Age \_\_\_\_ #2 M F Age \_\_\_\_ #3 M F Age \_\_\_\_ #4 M F Age \_\_\_\_ #5 M F Age \_\_\_\_

SIBLINGS: Circle your place in the family. If a sibling is deceased, put an X through the placement number.

#1 M F Age \_\_\_\_ #2 M F Age \_\_\_\_ #3 M F Age \_\_\_\_ #4 M F Age \_\_\_\_ #5 M F Age \_\_\_\_ #6 M F Age \_\_\_\_

Family Alcoholism or Domestic Violence? \_\_\_\_ Sexual Addictions or Abuse? \_\_\_\_

Parents divorced? \_\_\_\_ If yes, what year \_\_\_\_ Your age at the time \_\_\_\_\_

If deceased, what year? \_\_\_\_ Your age at the time \_\_\_\_ Cause of death \_\_\_\_\_

Any step-parents? \_\_\_\_ If yes, describe when and your relationship with them \_\_\_\_\_  
\_\_\_\_\_

If raised by someone other than your birth parents, describe: \_\_\_\_\_  
\_\_\_\_\_

**Legal Data:**

Have you ever been incarcerated (Jail or Prison)? Yes \_\_\_\_\_ No \_\_\_\_\_ Dates \_\_\_\_\_

Reason \_\_\_\_\_ Where \_\_\_\_\_

Have you ever had a DWI (Driving While Intoxicated)? Yes \_\_\_\_\_ No \_\_\_\_\_ How Many: \_\_\_\_\_

Are you currently on Probation? Yes \_\_\_\_\_ No \_\_\_\_\_ Explain \_\_\_\_\_

**Religious Data:**

Current Religious Preference: \_\_\_\_\_

In Childhood: \_\_\_\_\_

**Emotional Data:**

Describe your life now: Happy \_\_\_\_\_ Unhappy \_\_\_\_\_ Situational Stress \_\_\_\_\_ Anxious \_\_\_\_\_

Depressed \_\_\_\_\_ In Conflict \_\_\_\_\_ Suicidal Thoughts \_\_\_\_\_ List previous therapies or counseling for personal, emotional or marital problems:

<u>Dates:</u>	<u>Problem:</u>	<u>Type of Treatment:</u>	<u>Therapist:</u>

**Chemical Dependency Data:**

Have you ever been in treatment for Chemical Dependency/Addiction? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, Where: \_\_\_\_\_

Treatment was for what chemical: \_\_\_\_\_ Are you involved in a recovery program? Yes \_\_\_\_\_ No \_\_\_\_\_ Do you attend meetings? Yes \_\_\_\_\_ No \_\_\_\_\_ Have you completed a 12-step program? Yes \_\_\_\_\_ No \_\_\_\_\_ When \_\_\_\_\_ Do you have a sponsor? Yes \_\_\_\_\_ No \_\_\_\_\_

**Behavior – check any of the following behaviors that apply to you:**

- |   |  |  |  |   |
|---|--|--|--|---|
| <input type="checkbox"/> Overeat          | <input type="checkbox"/> Suicidal attempts   | <input type="checkbox"/> Can't keep a job  | <input type="checkbox"/> Take drugs          | <input type="checkbox"/> Compulsions                |
| <input type="checkbox"/> Insomnia         | <input type="checkbox"/> Vomiting            | <input type="checkbox"/> Smoke             | <input type="checkbox"/> Take too many risks | <input type="checkbox"/> Odd behavior               |
| <input type="checkbox"/> Withdrawal       | <input type="checkbox"/> Lack of motivation  | <input type="checkbox"/> Drink too much    | <input type="checkbox"/> Nervous tics        | <input type="checkbox"/> Eating problems            |
| <input type="checkbox"/> Work too hard    | <input type="checkbox"/> Procrastination     | <input type="checkbox"/> Sleep disturbance | <input type="checkbox"/> Crying              | <input type="checkbox"/> Impulsive reactions        |
| <input type="checkbox"/> Phobic avoidance | <input type="checkbox"/> Outbursts of temper | <input type="checkbox"/> Loss of control   | <input type="checkbox"/> Aggressive behavior | <input type="checkbox"/> Concentration difficulties |

**Feelings – check any of the following feelings that apply to you:**

- |                                     |                                   |                                    |                                    |                                  |                                   |
|-------------------------------------|-----------------------------------|------------------------------------|------------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Angry      | <input type="checkbox"/> Guilty   | <input type="checkbox"/> Unhappy   | <input type="checkbox"/> Annoyed   | <input type="checkbox"/> Happy   | <input type="checkbox"/> Bored    |
| <input type="checkbox"/> Conflicted | <input type="checkbox"/> Restless | <input type="checkbox"/> Depressed | <input type="checkbox"/> Regretful | <input type="checkbox"/> Lonely  | <input type="checkbox"/> Anxious  |
| <input type="checkbox"/> Contented  | <input type="checkbox"/> Fearful  | <input type="checkbox"/> Hopeful   | <input type="checkbox"/> Excited   | <input type="checkbox"/> Panicky | <input type="checkbox"/> Helpless |
| <input type="checkbox"/> Energetic  | <input type="checkbox"/> Relaxed  | <input type="checkbox"/> Tense     | <input type="checkbox"/> Envious   | <input type="checkbox"/> Jealous | <input type="checkbox"/> Others:  |

**Physical – check any of the following symptoms that apply to you:**

- |  |  |   |  |   |
|--|--|---|--|---|
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Stomach trouble | <input type="checkbox"/> Skin problems      | <input type="checkbox"/> Dizziness             | <input type="checkbox"/> Tics                     |
| <input type="checkbox"/> Dry mouth           | <input type="checkbox"/> Palpitations    | <input type="checkbox"/> Fatigue            | <input type="checkbox"/> Burning or itchy skin | <input type="checkbox"/> Muscle spasms            |
| <input type="checkbox"/> Twitches            | <input type="checkbox"/> Chest pains     | <input type="checkbox"/> Tension            | <input type="checkbox"/> Back pain             | <input type="checkbox"/> Rapid heart beat         |
| <input type="checkbox"/> Sexual disturbances | <input type="checkbox"/> Tremors         | <input type="checkbox"/> Unable to relax    | <input type="checkbox"/> Fainting spells       | <input type="checkbox"/> Blackouts                |
| <input type="checkbox"/> Bowel disturbances  | <input type="checkbox"/> Hear things     | <input type="checkbox"/> Excessive sweating | <input type="checkbox"/> Tingling              | <input type="checkbox"/> Watery eyes              |
| <input type="checkbox"/> Visual disturbances | <input type="checkbox"/> Numbness        | <input type="checkbox"/> Flushes            | <input type="checkbox"/> Hearing problems      | <input type="checkbox"/> Don't like being touched |

**Check any of the following that apply to you:**

	Never	Rare	Frequent	Often		Never	Rare	Frequent	Often
Marijuana					Heart problems				
Tranquilizers					Nausea				
Sedatives					Vomiting				
Aspirin					Insomnia				
Cocaine					Headaches				
Painkillers					Backaches				
Alcohol					Early morning awakening				
Coffee					Fitful sleep				
Cigarettes					Binge / Purge				
Narcotics					Poor appetite				
Stimulants					Eat "junk foods"				
Hallucinogens					Lack of interest in activities				
Diarrhea					Constipation				
Compulsive Exercise					High blood pressure				
Use Laxatives					Allergies				

**List 3 Strengths you believe you have:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**List 3 Weaknesses you believe you have:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**List 3 Support Systems you have in your life right now:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**List 3 Issues or Problems that you want to address now and obtain help with:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Personal Agreements**

I have read and signed the Telemedicine Consent Form OR Informed Consent and General Policy Forms, and have had the opportunity to ask any questions. (Please return these by FAX or bring with you to your appointment.

I understand that I may be asked to do certain “homework exercises” such as reading, journaling, changing behaviors, and otherwise acting in my own best interest. I understand that I am entirely responsible for my own actions and I will always make my own final decisions regarding counseling and the work I complete.

I further understand that much of the work done will be to resolve issues and will depend on my honesty, and willingness to do the things I need to do to move forward even if it is painful and difficult.

I understand that whatever I say in a session is strictly confidential and will not be released to anyone without my consent unless I am violating codes of abuse, harm to myself or others.

I agree to pay for all services rendered.

I understand that I will pay in full for appointments not cancelled with 24 hours notice.

\_\_\_\_\_ (client signature and date)

**A Personal Note from Dr. Lynne . . .** The love of people is what called me into this profession. I have had the privilege of working with thousands of individuals, and hope to provide you with the best professional services available. I am committed to regularly advance my clinical education to further my knowledge in the ever expanding field of mental health. My compassion and empathy for those who suffer emotionally, combined with my clinical experience and trainings are what I hope will make a difference in the quality of your life and relationships. And no matter what you may be going through in your life right now, the one thing I want to offer you is hope.