



**Lynne Angela Santiago, MS, LMHC**

*Licensed Psychotherapy & Consulting Services*

Healing ~ Growth ~ Empowerment

*Mental Wellness ~ Certified Sex Therapy*

### Intake Information

What brings you to this office: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How has this affected your family and/or job: \_\_\_\_\_

\_\_\_\_\_

Has there been any legal problems or any pending legal proceedings regarding this issue? \_\_\_\_\_

\_\_\_\_\_

How do you rate your physical health?: ☐ excellent ☐ good ☐ fair ☐ poor

Allergies: \_\_\_\_\_

Illness/Injuries

Date

Current treatment

\_\_\_\_\_

\_\_\_\_\_

History of therapy, counseling and/or psychiatric treatment (please list date, doctor, therapist, hospital, outcomes)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medications Currently Taking (include over the counter, herbal and/or diet supplements):

Drug	Dosage/Frequency	What is it for?	Side effects	Is it effective?
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_____	_____	_____	_____	_____
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Please check the services you are interested in receiving:

☐ Individual Psychotherapy

☐ Marriage/Family Counseling

☐ Life Coach Package

☐ Workshops/Seminars

☐ Individual Sex Therapy

☐ Therapy/Focus Groups

☐ Couples Intimacy Enrichment (Sex Therapy) Other: \_\_\_\_\_

**Below please rate the types of *feelings* you are having on a scale of 0-3  
(0=not at all, 1=Rarely, 2=Sometimes; 3=Often; 4=Daily)**

Anger: <input type="text"/>	Envious: <input type="text"/>	Forgetful: <input type="text"/>
Annoyed: <input type="text"/>	Guilty: <input type="text"/>	Unenthusiastic: <input type="text"/>
Sad: <input type="text"/>	Happy: <input type="text"/>	Confused: <input type="text"/>
Depressed: <input type="text"/>	Conflicted: <input type="text"/>	Disappointed: <input type="text"/>
Anxious: <input type="text"/>	Shameful: <input type="text"/>	Irritated: <input type="text"/>
Fearful: <input type="text"/>	Regretful: <input type="text"/>	Fatigued: <input type="text"/>
Panicky: <input type="text"/>	Content: <input type="text"/>	Muscle Aches: <input type="text"/>
Overly Energetic: <input type="text"/>	Hopeless: <input type="text"/>	Headaches: <input type="text"/>
Relaxed: <input type="text"/>	Tense: <input type="text"/>	Digestive Pain/discomfort: <input type="text"/>
Enthusiastic: <input type="text"/>	Motivate: <input type="text"/>	Jealous: <input type="text"/>
Optimistic: <input type="text"/>	Lonely: <input type="text"/>	Self Actualized: <input type="text"/>
Fear of others: <input type="text"/>	Fear of Abandonment: <input type="text"/>	Fear of nightmares: <input type="text"/>

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**Below please rate the types of behaviors or problems you may be experiencing  
on a scale of 0 to 3 (0=not at all, 1=rarely, 2=sometimes, 3=often, 4=daily)**

Aggression: <input type="text"/>	Depression: <input type="text"/>	Moodiness: <input type="text"/>
Sexual dysfunction: <input type="text"/>	Sexual disinterest: <input type="text"/>	Laziness: <input type="text"/>
Crying spells: <input type="text"/>	Temper outbursts: <input type="text"/>	Drug use: <input type="text"/>
Alcohol Abuse: <input type="text"/>	Suicide thoughts: <input type="text"/>	Suicide attempts: <input type="text"/>
Phobic Avoidance: <input type="text"/>	Can not maintain employment; <input type="text"/>	Withdrawal: <input type="text"/>
Sleep disturbance: <input type="text"/>	Over spending: <input type="text"/>	Working too much: <input type="text"/>
No Assertiveness: <input type="text"/>	Odd Behaviors: <input type="text"/>	Difficulties concentrating: <input type="text"/>
Over eating: <input type="text"/>	Risk-taking: <input type="text"/>	
Other impulsive/compulsive behavior: <input type="text"/>		

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**Which of the above behaviors are currently giving you the greatest concern for  
you and why?**


**Is there anything else you would like me to know?**


Signature Field

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Date/Time Field

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