Lynne Angela Santiago, PhD, LMHC
Licensed Psychotherapy & Consulting Services

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?

Please check the services you are interested in receiving:

_____ Individual Psychotherapy _____ Marriage/Family Counseling _____ Military Transition/Adjustment

_____ Life Coach Package _____ Workshops/Seminars _____ Sex Addiction

_____ Individual Sex Therapy _____ Therapy/Focus Groups _____ Childhood Trauma

_____ 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: _____ Envious: _____ Forgetful: _____
Annoyed: _____ Guilty: _____ Unenthusiastic: _____
Sad: _____ Happy: _____ Confused: _____
Depressed: _____ Conflicted: _____ Disappointed: _____
Anxious: _____ Shameful: _____ Irritated: _____
Fearful: _____ Regretful: _____ Fatigued: _____
Panicky: _____ Content: _____ Muscle Aches: _____
Overly Energetic: ____ Hopeless: ____ Headaches: _____
Relaxed: _____ Tense: ___ Digestive Pain/discomfort: _____
Enthusiastic: _____ Motivate: _____ Jealous: _____
Optimistic: _____ Lonely: _____ Self Actualized: _____
Fear of others: ____ Fear of Abandonment: _____ Fear of nightmares: _____
Loss of Meaning/Purpose_____ Feel like a burden on others _____

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: _____ Depression: _____ Moodiness: _____
Sexual dysfunction: _____ Sexual disinterest: _____ Laziness: _____
Crying spells: _____ Temper outbursts: _____ Easily irritated: _____
Drug use: _____ Alcohol Abuse: _____ Suicide thoughts: ____
Suicide attempts: _____ Self-injury: _____ Binging/purging: _____
Phobic Avoidance: _____ Cannot maintain employment/missing work; _____
Withdrawal/Isolating : _____ Forgetfulness:_____ Losing time: _____
Flashbacks: _____ Hyper-Arousal: _____ Distrust: _____ Avoiding:____
Sleep disturbance: _____ Over spending: _____ Working too much: _____
No Assertiveness: _____ Odd Behaviors: _____ Difficulties concentrating: ____
Over eating: _____ Risk-taking: _____
Other impulsive/compulsive behavior: _____

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? _____

_____

_____