Susan O'Dell, PhD

INTAKE FORM

(Please complete this form and email to susan@susanodellphd.com

If you're uncomfortable answering any of these questions, please indicate this in the space provided.

Date:_____

Name:_____

Date of Birth:_____

Names and ages of children, if any:_____

With whom do you live?_____
_____
_____

How do you define this/these relationship(s)?_____
_____
_____

What brings you therapy?_____
_____
_____
_____

Describe your previous counseling or mental health treatment experiences:_____
_____
_____
_____

Current physical or mental health diagnoses and medications:_____
_____

What do you think about your diagnosis and the medication you use?_____
_____

Intake Form—page 2

Past diagnoses and medication experience:_____

Please describe if and how you have been affected by trauma (abuse, domestic violence, accidents, injuries, death, neglect, etc.):_____

Is there anything you feel has been an ongoing or longstanding challenge for you?_____

Have you had substance abuse treatment previously? If so, when and where?_____

What are your goals for therapy?_____

Intake Form—page 3

Name:_____

Is there anything else you would like me to know about you?_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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State of Being Check List

If you're not comfortable answering any of these questions, please indicate this.

Name_____

How do you see yourself?

How do you think other people see you?

Have you been down, depressed, or hopeless in the last month?

Do you experience little interest or pleasure in doing things?

Has you appetite changed either eating more or less?

How much sleep do you get on average?
Is that enough?
Do you dream?

Has your sleep been disturbed either with insomnia or over-sleeping?

Do you feel worthless, shameful, or guilty?

Do you have sudden or unexpected bouts of anxiety or nervousness?

Do you feel tense, worried, or stressed?

Do you have acute onset of symptoms such as palpitations, shortness of breath or trembling?

Do you worry about a lot of different things?

State of Being Check List—page 2

Name_____

Do you avoid places or situations because of anxiety or worry?

Do you have recurrent, persistent or unwanted thoughts?

Do you have repetitive behaviors?

Have you been through any significantly stressful periods in the past 6 months?

In your lifetime, have you faced any potentially life-threatening events such as a natural disaster, serious accident, physical or sexual assault or abuse, military combat or child abuse?

If you've experienced any of these stressors, have you been easily startled?
Angry or irritable?
Emotionally numb or detached from your feelings?
Prone to physical reactions when reminded of the event?

Do you use prescription medicines or street drugs to relax, calm yourself, or get high?

Do you use alcohol, including social use?
About how much?

Have you made an effort to cut down on your drinking or drug use?

Have you been annoyed by people who criticize your drinking or drug use?

State of Being Check List—page 3

Name_____

Do you feel guilty about your drinking or drug use?

Do you ever drink or use drugs to steady yourself, get rid of a hangover, or relieve withdrawal symptoms?

Do you use tobacco in any form?
About how much?

Do you use caffeine, including cola drinks?
About how much?

Have you ever attempted suicide?
If yes, when?

Do you have thoughts of seriously harming yourself or others now?

Thank you for your thoughtful responses to these questions. This information will be helpful to both of us as we talk about your goals for therapy.