Body Psychology

KATHY MACCHIONE LEGGETT, LMHC #MH11046
OFFICE (863) 207-4402
BODYPSYCHWELLNESS@gmail.com

INTAKE FORM

Please fill out the following questionnaire to the best of your ability.

Date: _____

First Name _____ Last Name _____

Date of Birth:_____ Age: _____ Gender: _____

Single / Engaged / Married / Divorced / Widowed / Co-habitant Relationship

Email: _____ Cell#: _____

Address: _____

MAY WE CONTACT YOU VIA EMAIL: ___YES ____NO

#1 Contact number (_____)_____ #2 Contact number (_____)_____

May we contact you at both phone numbers? _____ What are the best times to reach you?

_____

Who referred you to counseling? Self: ____ Friend: ____ Other:_____

Name of referral:_____

Emergency Contact Person: _____ Phone: _____

EDUCATION/JOB HISTORY

Level of Education: ___ GED ___ HIGH SCHOOL ___ COLLEGE ___ POST GRADUATE

Current Job: _____

How long at current job: _____ Are you satisfied with your job? YES/NO

Previous Job History:

_____

_____

_____

_____

CURRENT EMOTIONAL WELLNESS

Describe the situation and/or symptoms for which you are seeking help:

_____

_____

_____

_____

How long have this situation and/or symptoms been present? _____

PLEASE RATE THE SEVERITY:

___ **Not Serious-**Does not affect satisfaction/ability to cope with life and activities

___ **Minimal** in everyday life and activities (everyday problems or concerns)

___ **Mild symptoms**-some difficulty in social/occupational/school functioning but generally functioning pretty well

___ **Moderate symptoms**-difficulty in social/occupational/school-functioning (few friends, conflicts w/peers)

___ **Serious symptoms-**difficulty in social/occupational/school functioning (suicidal ideation, obsessive rituals, no friends, unable to keep a job)

___ **Major impairment-**in some area-communication/social/occupation/school or family relations, judgment or mood (neglects family, avoids friends, neglects family, unable to work, defiant)

___ **Serious-**Behavior is influenced by delusions/hallucinations and there is serious impairment of communication or judgment and /or inability to function in life or activities (speech incoherent, suicidal preoccupation, no job, home, or friends, stays in bed all day)

SYMPTOMS CHECKLIST

Please Check and describe the following symptoms as they apply to your life:

Problems and Symptoms	*Past*	*Present*	*Explanation*
Change of Appetite	☐	☐	
Bingeing/purging food	☐	☐	
Weight loss/gain	☐	☐	
Trouble Sleeping	☐	☐	
Withdrawing from Others	☐	☐	
Depression	☐	☐	
Mood Swings	☐	☐	
Anxiety	☐	☐	
Obsessive Thoughts	☐	☐	
Compulsive Behaviors	☐	☐	
Anger Management	☐	☐	
Cruelty to Animals	☐	☐	
Fire setting	☐	☐	
Aggression	☐	☐	
Lying	☐	☐	
Stealing	☐	☐	
Sexual Acting Out	☐	☐	
Nightmares/night terrors	☐	☐	
Fears	☐	☐	
Body Aches/Headaches	☐	☐	
Abuse/neglect	☐	☐	
Grief/loss	☐	☐	
Stress	☐	☐	
Flash Backs	☐	☐	
Financial	☐	☐	
Addictive Behavior	☐	☐	
Impulsivity	☐	☐	
Hyperactivity	☐	☐	
Poor Concentration	☐	☐	
Short Attention Span	☐	☐	
Poor Memory	☐	☐	
Hard Time Understanding	☐	☐	
Poor Family Relations	☐	☐	

Poor Relations/School/Work	☐	☐	
Poor Relations with Peers	☐	☐	
Hallucinations/delusions	☐	☐	
Difficulty with Authority	☐	☐	
Spiritual Issues	☐	☐	
Feeling of Low Self Worth	☐	☐	
Thoughts of Suicide	☐	☐	
Cutting	☐	☐	
Other	☐	☐	

FAMILY BACKGROUND

Are you married? [ ] Yes [ ] No

Spouses Name: _____ Occupation: _____

If not married, are you in a significant relationship? [ ] Yes [ ] No
Are you living together? [ ] Yes [ ] No

Significant Other's Name: _____ Occupation: _____

Any previous marriages? [ ] Yes [ ] No – If Yes, date and length of those marriages:

1. _____ 2. _____ 3. _____ 4. _____

Are you currently experiencing any problems in your marriage/relationship? If yes, please describe:

_____

_____

Children: YES/NO – If yes, Names and Ages:

NAME: _____ AGE: _____

NAME: _____ AGE: _____

NAME: _____ AGE: _____

NAME: _____ AGE: _____

Mother's name: _____ Occupation: _____

If deceased – Date and Cause of Death: _____

Mother's Present Status: SINGLE/MARRIED/DIVORCED/SEPARATED/WIDOWED/
SIGNIFICANT RELATIONSHIP

Number of marriages: _____ Length of each marriage? _____ _____ _____

Describe your relationship with your mother.

_____

_____

Step-Father's name: _____ Occupation: _____

If not married,
significant other's name:_____ Occupation:_____

Mother currently living with significant other? Yes/No If yes, how long?_____

Describe your relationship with your step-father/mother's significant other.

_____

_____

Father's name: _____ Occupation: _____

If deceased – Date and Cause of Death: _____

Present Status: SINGLE/MARRIED/DIVORCED/SEPARATED/WIDOWED/
SIGNIFICANT RELATIONSHIP

Number of marriages: _____ Length of each marriage? _____ _____ _____

Describe your relationship with your father.

_____

_____

Step-Mother's name: _____ Occupation: _____

If not married,
significant other's name:_____ Occupation:_____

Father currently living with significant other? Yes/No If yes, how long?_____

Describe your relationship with your step-mother/father's significant other.

_____

_____

LIST BROTHERS, SISTERS, STEP-BROTHERS, STEP-SISTERS, HALF BROTHERS, HALF SISTERS - If more room is needed use the back of the page.

Name	Age	Relationship	Living in Household?

Describe your relationship with your siblings?

_____

_____

Please list anyone else living in the household?

_____

_____

_____

Who do you get along with well and why?

_____

_____

_____

Who do you not get along with well and why?

_____

_____

_____

Who in your family are you the closest to? _____

Why?_____

Describe to me what makes your family strong?

_____

_____

Describe how you would change your family if you could?

_____

_____

Do/Did your parents get along? Yes/No What do they do that tells you they get along or not?

_____

_____

_____

Do/Did your parents argue? Yes/No If yes, how do they argue?

_____

_____

MEDICAL HISTORY

Have you received previous counseling? YES/NO

If yes, please list counselors name and when you received services:

_____

_____

Have you ever had the following (if yes, please describe):

Major Illness_____ Date: _____

_____ Date: _____

Serious Physical Injury _____ Date: _____

_____ Date: _____

Accident _____ Date: _____

_____ Date: _____

How would you describe your current health?
___ Excellent ___ Good ___ Fair ___ Poor

Please describe any current medical problems:

_____

_____

_____

_____

Primary Care Physician:

_____

Please list any surgeries or hospitalizations (Please provide approximate dates.)

_____

_____

_____

List any medications you are taking or have taken in the last 6 months:

Medication Dose Reason Prescribed: By-Physician:

_____

_____

_____

_____

Please list any other medical personnel that are involved in your health/medical care (i.e. nutritionist, personal trainer, wellness coach, etc.):

_____

_____

Nutrition:

Do you eat a balanced diet? YES/NO

How much caffeine do you consume daily (8 oz cups of coffee/tea, 12 oz sodas etc.)_____

How many Alcoholic drinks do you consume: 1-3 Daily 1-3 Weekly 1-3 Monthly None

How much fast food do you eat: 1-3 Daily 1-3 Weekly 1-3 Monthly None

Energy level: lethargic low average high hyperactive

How would you rate your current health: poor fair good excellent

List any food allergies you have:

_____

How would you rate your weight/height/body fat ratio: poor fair good excellent

On a scale of 1-10, 10 being very satisfied, how satisfied are you with your body image: _____

Please describe any difficulties you are having with health, nutrition, body image:

_____

_____

HISTORY WITH THE FOLLOWING ITEMS:

	Tried	Daily	Weekly	Monthly	Never Tried
Gambling	☐	☐	☐	☐	☐
Pornography	☐	☐	☐	☐	☐
Food/Binging	☐	☐	☐	☐	☐
Cutting/Self-Mutilation	☐	☐	☐	☐	☐

SUBSTANCE ABUSE HISTORY

1. How often do you drink alcohol?

    a. □ only on the weekends
    b. □ several times a week
    c. □ few times a month
    d. □ Rarely
    e. □ I don't drink

2. How often do you smoke marijuana?

    a. □ only on the weekends
    b. □ several times a week
    c. □ few times a month
    d. □ Rarely
    e. □ I don't smoke

3. How often do you use other drugs?

    a. □ only on the weekends
    b. □ several times a week
    c. □ few times a month
    d. □ Rarely
    e. □ I don't use any other substances

Have you ever felt like you should cut down on your alcohol or other drugs use (including prescription drugs)?

____Yes ____No

Has a friend or relative discussed concerns about your drug use?

____Yes ____No

Have you ever felt guilty about your drinking or drug use?

____Yes ____No

Have you ever had to take a drink or use a drug the next day to steady your nerves?

____Yes ____No

Are you a recovering alcoholic or recovering drug addict?

____Yes ____No

Is there a history of problems with alcohol or drug use in your family?

____Yes ____No

TRAUMA/ABUSE HISTORY

Below are traumatic events that sometimes happen to people. Check ***one or more*** of the choices:

Serious accident:

- ☐ *it happened to you* personally
- ☐ *witnessed it* happen to someone else
- ☐ it *happened to someone close to you*
- ☐ you're *not sure* if it fits
- ☐ it *doesn't apply* to you

Life-threatening illness or injury:

- ☐ *it happened to you* personally
- ☐ you *witnessed it* happen to someone else
- ☐ it *happened to someone close to you*
- ☐ you're *not sure* if it fits
- ☐ it *doesn't apply* to you

Attacked, hit slapped, kicked, beaten up:

- ☐ *it happened to you* personally
- ☐ you *witnessed it* happen to someone else
- ☐ it *happened to someone close to you*
- ☐ you're *not sure* if it fits
- ☐ it *doesn't apply* to you

Shot, stabbed, threatened with a knife, gun, or bomb:

- ☐ *it happened to you* personally
- ☐ you *witnessed it* happen to someone else
- ☐ it *happened to someone close to you*
- ☐ you're *not sure* if it fits
- ☐ it *doesn't apply* to you

Ever raped, forced or threatened to perform any type of sexual act:

- ☐ *it happened to you* personally
- ☐ you *witnessed it* happen to someone else
- ☐ it *happened to someone close to you*
- ☐ you're *not sure* if it fits
- ☐ it *doesn't apply* to you

Other unwanted or uncomfortable sexual experience:

- ☐ *it happened to you* personally
- ☐ you *witnessed it* happen to someone else
- ☐ it *happened to someone close to you*
- ☐ you're *not sure* if it fits
- ☐ it *doesn't apply* to you

Ever kidnapped, abducted, or held hostage:

- ☐ *it happened to you* personally
- ☐ you *witnessed it* happen to someone else
- ☐ it *happened to someone close to you*
- ☐ you're *not sure* if it fits
- ☐ it *doesn't apply* to you

Sudden, violent death (homicide/ suicide):

- ☐ *it happened to you* personally
- ☐ you *witnessed it* happen to someone else
- ☐ it *happened to someone close to you*
- ☐ you're *not sure* if it fits
- ☐ it *doesn't apply* to you

Unexpected death of someone close to you:

- ☐ *it happened to you* personally
- ☐ you *witnessed it* happen to someone else
- ☐ it *happened to someone close to you*
- ☐ you're *not sure* if it fits
- ☐ it *doesn't apply* to you

Incarceration or arrest:

- ☐ *it happened to you* personally
- ☐ you *witnessed it* happen to someone else
- ☐ it *happened to someone close to you*
- ☐ you're *not sure* if it fits
- ☐ it *doesn't apply* to you

Any other very stressful event or experience:

- ☐ *it happened to you* personally
- ☐ you *witnessed it* happen to someone else
- ☐ it *happened to someone close to you*
- ☐ you're *not sure* if it fits
- ☐ it *doesn't apply* to you

SELF HARM ASSESSMENT

Please check the number beside the statement or phrase that best applies to you.

1. Have you ever thought about or attempted to kill yourself? (check one only)
    a. ☐ Never
    b. ☐ It was a brief passing thought
    c. ☐ I have had a plan at least once to kill myself but did not try to do it
    d. ☐ I have had a plan at least once to kill myself and really wanted to die

e. ☐ I have attempted to kill myself, but did not want to die
f. ☐ I have attempted to kill myself, and really hoped to die
g. ☐ I have been Baker Acted in the past

2. How often have you thought about killing yourself in the past year? (check one only)
   a. ☐ Never
   b. ☐ Rarely (1 time)
   c. ☐ Sometimes (2 times)
   d. ☐ Often (3-4 times)
   e. ☐ Very Often (5 or more times)

3. Have you ever told someone that you were going to commit suicide, or that you might do it? (check one only)
   a. ☐ No
   b. ☐ Yes, at one time, but did not really want to die
   c. ☐ Yes, at one time, and really wanted to die
   d. ☐ Yes, more than once, but did not want to do it
   e. ☐ Yes, more than once, and really wanted to do it

4. How likely is it that you will attempt suicide someday? (check one only)
   a. ☐ Never
   b. ☐ No chance at all
   c. ☐ Rather unlikely
   d. ☐ Unlikely
   e. ☐ Likely
   f. ☐ Rather likely
   g. ☐ Very likely

5. Have you ever thought about or attempted to kill someone else?
   a. ☐ Never
   b. ☐ It was a brief passing thought
   c. ☐ I have had a plan at least once to kill someone but did not try to do it
   d. ☐ I have had a plan at least once to kill someone and really wanted them to die
   e. ☐ I have attempted to kill someone, but did not want them to die
   f. ☐ I have attempted to kill someone, and really hoped they would die

---

LEGAL HISTORY/ARREST/PROBATION

Have you ever been arrested? Yes/No Have you ever been on probation? Yes/No

If yes, what were your charges? _____

_____

_____

SOCIAL HISTORY

Do you have friends? [ ] Yes [ ] No How do you get along with those friends?

_____

_____

_____

Has there been a change in your circle of friends lately? [ ] Yes [ ] No

Are there any people in your life you can talk to about your problems? Yes/No

If yes, who: _____

Please describe any difficulties you are having socially:

_____

_____

_____

SPIRITUAL BACKGROUND

Are there any special religious, cultural, or ethnic considerations I should be aware of? Yes/No

Spiritual History:
Do you believe in God? Yes/No Do you believe in Jesus Christ? Yes/No

Do you have a religious affiliation with which you are active? Yes/No
If Yes, what church/religious affiliation do you belong?

_____

How does your faith help you to cope with life's problems?

_____

_____

What spiritual disciplines do you practice and how much time do you spend (i.e. prayer, Bible reading, Bible study, worship, etc?)

_____

_____

Please describe any difficulties you are having concerning your faith

_____

_____

Would you like to be counseled from a Biblical perspective? _____

GOALS FOR COUNSELING

What three things would you like to change by participating in counseling?

1._____

2._____

3._____

What do you think it will require on your part to make these changes?

_____

_____

_____

List 3 major strengths or things you like about yourself?

1. _____
2. _____
3. _____

List 3 major weaknesses or things you don't like about yourself?

1. _____
2. _____
3. _____