north shore senior options
positive aging support services

A Program of North Shore Senior Center
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Confidential Counseling Intake Form

1. Name: ____

2. Address:____

3. Phone #:______________________________(Cell) Can we leave a message? Yes or No (circle)

   ____________________________________(Home) Can we leave a message? Yes or No (circle)

4. Email Address (Please note I will not discuss confidential matters via email):

   ____

5. Date of Birth:____

6. I Identify my Gender as:____

7. Marital Status:____

8. Are you currently in a relationship? Yes or No (circle)

9. Do you have support/s in your life? ____

10. Emergency Contact
    Information:____

11. Primary Health Insurance Provider (Please provide ID# and Group #):

    ____

12. Secondary Health Insurance Provider (Please Provide ID# and Group #):

    ____

13. What are the concerns that brought you here today:

    ____

    ____

    ____

    ____

    ____

14. Current Areas of Concerns:
    Have you recently experienced any of the following? (Mark all that apply)
    Difficulties with Concentration/Forgetfulness (circle)__
    Excessive Worry__
    Fatigue/Loss of Energy_
    Feeling Restless__
    Feeling Sad/Down__
    Feelings of Worthlessness or Guilt (circle)__
    Grief/Loss__
    Homicidal Thoughts__
    Hopelessness__
    Increased Irritability__
    Loneliness__
    Sleep Pattern Disturbance__
    Suicidal Thoughts__
    Unable to enjoy activities __
    Weight Loss/Gain(circle)__

15. Current
    Medications/Supplements:____

    ____

    a. Prescribing Physician____

16. Past Psychotropic
    Medications:____

    ____

17. Name of Primary Care Physician:____

18. Any History of Mental Health Treatment:____

    ____

19. History of Psychiatric

    Hospitalizations:____

    ____

20. Current Health
    Conditions:____

    ____
    (if not listed below)

    a. Adult onset diabetes______
    b. Alzheimer's disease______
    c. Anxiety______
    d. Arthritis______
    e. Cardiovascular disease______
    f. Cataracts______
    g. Chronic Obstructive Pulmonary Disease (COPD)______
    h. Dementia______
    i. Depression______
    j. Glaucoma______
    k. High Blood Pressure_____
    l. Kidney and bladder problems______
    m. Macular degeneration______
    n. Parkinson's disease______
    o. Osteoporosis______
    p. Shortness of Breath_____
    q. Sleep Issues Increased or Decreased (circle)______
    r. Stroke _____
    s. Thyroid Condition_____

21. Are you currently experiencing pain? (If yes, please explain)

    ____

    ____

22. How would you describe your current sleep
    habits?____

23. Suicide Risk Assessment:

Have you ever had feelings or thoughts that you didn't want to live?______________________________

If **YES,** please answer the following:

a. Do you currently feel that you don't want to live? ____
b. How often do you have these thoughts?

   ____
c. Do you feel hopeless and/or worthless? ______________
d. Have you ever tried to kill or harm yourself before? ____

24. Is there a history of suicide in your family? If yes, please provide basic information regarding these events. ____

    ____

25. Do you have access to guns? If yes, please explain:

    ____

26. Have you ever had thoughts or feelings you wanted to harm someone else?

    ____

27. Do you believe that you have been abused, neglected or exploited?____

28. Do you currently drink alcohol?: Yes or No (circle) If **YES,** please answer the following:

    a. How many alcoholic beverages do you consume per week? ________________________________
    b. Do you have any concerns about your alcohol use?____
    c. Have family or friends expressed concerns about your alcohol use?_________________________

29. Do you currently use any non-prescribed drugs, such as herbal medications or recreational drugs?: Yes or No (circle) ____

30. Any history of substance abuse treatment **or** are you currently receiving treatment?____

31. Do you currently work/volunteer?

    ____

32. Are you a Veteran?____

33. Do you belong to a religious or spiritual group? If so, what is your level of involvement?____

34. Have you ever been arrested? If yes, what were the charges?

35. Do you have current legal charges pending?____

36. Is there anything else that you feel would be helpful for me to know?____

37. What are your goals for treatment?____

Additional Information, if any:

Thank you for completing this form.