Lasting transformation.

Laura C. Strom

Trauma & Disabilities Specialist
Licensed Marriage and Family Therapist LMFT49174
Licensed Professional Clinical Counselor LPCC149
Certified Rehabilitation Counselor CRC 00113822
Registered Play Therapist RPT 3178

First name	
Last name	
Date	

Intake Form—Page 1 of 4

Please complete the following form for your first session. The information you provide will be considered confidential.

Name _____
(Last) (First) (Middle)

Name of parent or guardian if client is under 18

_____
(Last) (First) (Middle)

Physical address _____

Mailing address _____

Date of birth _____ Age _____ Gender Identification _____

Cell phone _____ May we leave a message? ❑Yes ❑No

Home phone _____ May we leave a message? ❑Yes ❑No

Work phone _____ May we leave a message? ❑Yes ❑No

Email address _____ May we email you? ❑Yes ❑No
**Please note that email is not considered a confidential form of communication.*

Your occupation _____

Your employer _____ Years there _____

Children's names/ages _____

Who lives with you in your home? _____

Relationship legal status ❑Never married ❑Domestic partnership ❑Married ❑Divorced ❑Separated ❑Widowed

Sexual orientation _____ Ethnic/Cultural identity _____

Referred by _____ Today's date _____

What brings you here today? _____

_____

_____

Laura C. Strom, MS, Trauma & Disabilities Specialist
Cell/Business Phone: 707-889-9168
Web: http://lauracstrom.com • Email: LCStrom@gmail.com
Office: 3442 Mendocino Ave., Suite A, Bldg E, Santa Rosa, CA 95403
Mailing: P.O. Box 353, Monte Rio, CA 95462

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Please complete the following form for your first session. The information you provide will be considered confidential.

Your highest level of education _____

(For children) Name of school and grade level _____

Years in current relationship _____ Satisfied? _____

Spouse/Partner's name _____ Age ____ Occupation _____

Siblings (names, ages) _____

Parents or step-parents _____

Other important people in your life _____

Pets? Please describe _____

I give my permission for Laura Strom, LMFT to contact any of these people in an emergency:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Current medical doctor _____ Phone _____

Current psychiatrist _____ Phone _____

List all psychiatric medications/dosages you currently take _____

_____

List all other medications/dosages you currently take including over-the-counter meds, medical marijuana, vitamins, etc.

_____

Have you ever been hospitalized for a psychiatric emergency? ❑Yes ❑No

If yes, please describe _____

Number of jobs you have held _____ Number of places you have lived _____

Have you ever been homeless? _____

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Intake Form—Page 3 of 4

Please use back of paper if needed.

How do you rate your current health? ❑Poor ❑Unsatisfactory ❑Satisfactory ❑Good ❑Very Good

Describe any current health concerns _____

_____

How do you rate your current sleep? ❑Poor ❑Unsatisfactory ❑Satisfactory ❑Good ❑Very Good

Have you ever been told you snore? ❑Yes ❑No Ever been tested for sleep apnea? ❑Yes ❑No

Describe any current sleep concerns _____

How often do you exercise? _____ Type of exercise _____

If you are experiencing any difficulties with your appetite or eating, please describe _____

_____

Are you currently experiencing any anxiety/panic attacks, phobias? ❑Yes ❑No Frequency? _____

If yes, please describe _____

How often do you use alcohol? ❑Daily ❑Weekly ❑Monthly ❑Infrequently ❑Never

How often do you use recreational drugs? ❑Daily ❑Weekly ❑Monthly ❑Infrequently ❑Never

Have you ever attempted suicide? ❑Yes ❑No If yes, please describe what happened _____

_____

Have you ever suffered a head injury (e.g., concussion)? ❑Yes ❑No
Was there a loss of consciousness? ❑Yes ❑No If yes, how long?_____

Describe what happened _____

Do you consider yourself to be spiritual/religious? ❑Yes ❑No If yes, please describe your

spiritual practice_____

Previous counselors you have seen (please list dates of treatment) _____

_____

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Intake Form—Page 4 of 4

Please use back of paper if needed.

Family history—please identify if there is a family history of any of the following and indicate the person's relationship (myself, grandmother, brother, etc.)

Alcohol or substance abuse	❑Yes	❑No	_____
Anxiety	❑Yes	❑No	_____
Autoimmune disorders	❑Yes	❑No	_____
Bipolar disorder	❑Yes	❑No	_____
Child Sexual Abuse	❑Yes	❑No	_____
Depression	❑Yes	❑No	_____
Diabetes	❑Yes	❑No	_____
Dementia	❑Yes	❑No	_____
Domestic violence	❑Yes	❑No	_____
Eating disorders	❑Yes	❑No	_____
Manic behavior	❑Yes	❑No	_____
Obesity	❑Yes	❑No	_____
Panic attacks	❑Yes	❑No	_____
Obsessive compulsive behavior	❑Yes	❑No	_____
Schizophrenia	❑Yes	❑No	_____
Sexual abuse/rape	❑Yes	❑No	_____
Sleep apnea	❑Yes	❑No	_____
Suicidality	❑Yes	❑No	_____

Have you experienced any trauma in your life? If so, please describe what happened _____

_____

_____

What causes you stress? _____

_____

_____

What do you consider to be your strengths? _____

_____

_____

Describe your support network _____

_____

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Treatment Goals/Plan

Please use back of paper if needed.

This page is for us to create a set of treatment goals and a way to measure how the problems that currently bother you are improving.

What are the problems which are bothering you the most right now? _____

_____

_____

How will you know when these problems have improved? _____

_____

_____

What behaviors are you seeking to change? _____

_____

What new behaviors do you wish to adopt? _____

_____

We'll do this next part together. Our treatment goals will be….
Problem _____ As evidenced by _____
Goal _____ By _____
Intervention _____

Problem _____ As evidenced by _____
Goal _____ By _____
Intervention _____

Problem _____ As evidenced by _____
Goal _____ By _____
Intervention _____

We agree to work on these goals together and reevaluate them in ____ days.
Signed by:

Client _____ Date _____

Therapist _____ Date _____

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