Norine E. Lyons, M.A., LPC
1202 Prince Street
Alexandria, VA 22314
703 548-0090
norine@norinelyons.com
VA LPC: license 0701004105
DC LPC: license PRC13999

Intake information

Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session, or allow yourself 30 minutes prior to your appointment to complete the form in the office. If your appointment is within a few days, please bring the form with you. If you prefer not to answer a question, leave it blank; if a question does not apply to your situation, write "NA."

About You

1. Name: _____
(Last) (First) (Middle Initial)

2. Address: _____

_____
(City) State Zip

3. Home Phone: ( ) May we leave a message? ___Yes ___ No

4. Cell/Other Phone: ( ) May we leave a message? ___Yes ___ No

5. E-mail: _____ May we email you? ___Yes ___ No
*Please be aware that email might not be confidential.

6. Birth Date: _____ Age: _____

7. Gender: ____ Female ____ Male

8. Marital Status: ____ Never married ____ Married ____Separated ____ Divorced ____ Partnered

9. Number of children: ____ Ages:_____

10. Referred by: _____

11. Are you currently receiving psychiatric services or psychotherapy elsewhere?
____ No ____ Yes

12. Have you had previous psychotherapy?

____ No ____ Yes-Previous therapist's name: _____

13. Are you currently taking prescribed psychiatric medication (antidepressants or others)?

____ No ____ Yes-Please list _____

14. If no, have you been previously prescribed psychiatric medication?

____ No ____ Yes-Please list _____

Health and Social Information

1. How is your physical health at present?

____ Poor ____ Unsatisfactory ____ Satisfactory ____ Good ____ Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

---

3. Are you having any problems with your sleep habits? ____ No ____ Yes

If yes, check where applicable:

____ Sleeping too little ____ Sleeping too much ____ Poor quality sleep

____ Disturbing dreams ____Other: _____

4. How many times per week do you exercise? ____

Approximately how long each time? _____

5. Are you having any difficulty with appetite or eating habits? ____ No ____ Yes

If yes, check where applicable: ___ Eating less ____ Eating more

___ Bingeing ____ Restricting

Have you experienced significant weight change in the last 2 months? ____ No ____Yes

6. Do you regularly use alcohol? ____ No ____Yes

In a typical month, how often do you have 4 or more drinks in a 24-hour period? ____

7. How often do you engage recreational drug use?

____ Daily ____ Weekly ____ Monthly ____ Rarely ____ Never

8. Have you had suicidal thoughts recently?

____ Frequently ____ Sometimes ____ Rarely ____ Never

Have you had them in the past? ____ Frequently ____ Sometimes ____Rarely ____ Never

9. Are you currently in a romantic relationship? ____ No ____ Yes

If yes, how long have you been in this relationship? _____

On a scale of 1-10, how would you rate the quality of your current relationship? _____

10. In the past year, have you experienced any significant life changes or stressors:

_____

_____

11. Have you ever experienced (check all that apply):

____ Extreme depressed mood
____ Wild mood swings
____ Rapid Speech
____ Extreme anxiety
____ Panic attacks
____ Phobias
____ Sleep disturbances
____ Hallucinations
____ Unexplained losses of time
____ Unexplained memory lapses
____ Alcohol/substance abuse
____ Frequent body complaints
____ Eating disorder
____ Body image problems
____ Repetitive thoughts (e.g., obsessions)
____ Repetitive behaviors (e.g., frequent checking, hand-washing)
____ Homicidal thoughts
____ Suicide attempt

Family Mental Health History

1. Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (check any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty	**Family Member**
Depression	_____
Bipolar disorder	_____
Anxiety disorders	_____
Panic attacks	_____
Schizophrenia	_____
Alcohol/substance abuse	_____
Eating disorders	_____
Learning disabilities	_____
Trauma history	_____
Suicide attempts	_____

Occupational Information

1. Are you currently employed? ____No ____Yes

   If yes, who is your current employer/position? _____

   If yes, are you happy at your current position? ____ No ____ Yes

2. Please list any work-related stressors, if any: _____

Other Information

What do you consider to be your strengths?

What do you like most about yourself?

What are effective coping strategies that you've learned?

What are your goals for therapy?