DRCoughlin
Licensed Mental Health Counselor

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ADULT LEGAL INTAKE FORM

Referred by: _____ Date: _____

Name: _____ DOB: _____

Home Address: _____

City/State: _____Zip _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Employer: _____ Occupation: _____

Should contact only be made through your attorney? YES NO

Attorney Name: _____ Phone _____

I authorize Wendy E. Coughlin, PhD and my attorney to disclose information to each other about my case.

_____ _____

Signature Date

Brief description of legal action with which you are involved. _____

_____

Is this Pre or Post Court? Pre Post When is your court date? _____

Have you ever been arrested or convicted of any crimes in the past? If yes, please explain when and what the charges were:

_____

Primary Care Physician:_____ Phone: _____

Address: _____

City / State: _____ Zip: _____

Person Responsible for Payment:_____ Phone: _____

Address:_____

City / State: _____ Zip: _____

Relationship: _____ Driver's License #:_____

Employer: _____ Occupation: _____

Have you ever been in therapy before? Yes No

If Yes, briefly provide details: _____

_____

Have you ever been hospitalized for mental disorders? Yes No

If Yes, briefly provide details: _____

_____

Describe your usual diet, including beverages:

- Breakfast:_____
- Lunch:_____

  Dinner:_____
- Snacks:_____

Do you drink caffeinated beverages? **YES ☐ NO ☐** If yes, quantity: _____

Name: _____SS#: _____ Date: _____

What medical problems, if any, are you currently having?

_____

_____

Are those problems being treated? **YES ☐ NO ☐** By whom? _____
Last medical examination (date): _____
Primary care doctor: _____
Current psychotherapy medication (include dosage and schedule):

_____

_____

Prescribing Physician: _____ **PCP ☐ Psychiatrist ☐**

What prescription or non-prescription drugs (including alcohol) are you currently taking or have taken in the last six months?

_____

_____

List past hospitalizations, operations, or serious illnesses:

- _____Year: _____
- _____Year: _____

Check any of the following diseases you have had:

Disease	**At what age?**	**Disease**	**At what age?**
☐ Thyroid Disorder	_____	☐ Diabetes	_____
☐ Chronic Bronchitis	_____	☐ Cancer	_____
☐ Emphysema	_____	☐ Heart Disease	_____
☐ Epilepsy (convulsion)	_____	☐ Stroke	_____
☐ Venereal Disease	_____	☐ Anemia	_____
☐ Asthma	_____	☐ Kidney Disease	_____
☐ Hay Fever	_____	☐ Liver Disease	_____
☐ Nervous Disorder	_____	☐ Hepatitis	_____
☐ Other	_____	☐ Other	_____

Do you use tobacco? **YES ☐ NO ☐** What form? _____

WOMEN ONLY:
Are you pregnant? **YES ☐ NO ☐**
Perimenopausal? **YES ☐ NO ☐**

Family history with alcohol and/or drugs?

_____

_____

_____

Do you drink alcoholic beverages? **YES ☐ NO ☐**
How often do you drink? **Daily ☐ 3-5 times per week ☐ 1-2 x per week ☐ Less ☐**
Do you sometimes drink more than you had planned? **YES ☐ NO ☐**
Have family of friends expressed concern about your drinking before? **YES ☐ NO ☐**

Have you ever been arrested for alcohol-related charges? **YES** ☐ **NO** ☐

Have you ever had an episode where you were unable to remember periods when you are drinking? **YES** ☐ **NO** ☐

Have you been treated for addictive illness before? **YES** ☐ **NO** ☐

If so, when? _____

Indicate which of the following you use (or have used):	**Within 1 year**	**Used in past**
Tranquilizers: Valium ☐ Xanax ☐ Ativan ☐ Klonopin ☐ Other ☐		
Pain Pills: Darvocet ☐ Oxycontin ☐ Hydrocodone ☐ Vicodin ☐ Percocet ☐ Morphine ☐ Heroin ☐ Methadone ☐ Other ☐		
Stimulants: Amphetamines ☐ "Speed" ☐ Dexedrine ☐ Adderall ☐ Caffeine ☐ Other ☐		
Sleeping Pills: Lunesta ☐ Restoril ☐ Ambien ☐ Other ☐		
"Street Drugs": Marijuana ☐ Crystal Meth ☐ "Shrooms" ☐ Cocaine ☐ Ecstasy ☐ Acid ☐ Crack cocaine Other		
Volatiles: Aerosols ☐ Glue Whippets Other ☐		
Others:		

Describe your usual sleep pattern:

_____

_____

Do you snore? **YES** ☐ **NO** ☐