Gina LaRose, LPC, LLC
Gina LaRose Tedesco, LPC, LMFT
4833 Conti St., Suite 202
New Orleans, LA 70119
(985) 265-7210

CLIENT INFORMATION

Name:_____
Date of birth: _____ Age: _____

Address:_____
City: _____ State: _____
Zip Code: _____

Phone #: _____
Alternate Number: _____
May I leave a confidential message? Yes No
E-mail address: _____
I would like appointment reminders. Yes No
If yes, please indicate which type: E-mail Text
How did you hear about this Therapist?
_____

OCCUPATION & STATUS INFORMATION

Job Title: _____
Employer:_____
Employer Location: _____
Annual Income: _____
# of dependents: ____
Education level completed: _____
Military experience: Y N Branch: _____
Marital Status: _____
How long has this been your marital status? _____

With whom do you live? Alone Friend Family Spouse/Partner Other: _____
How long has this been your residence? _____

EMERGENCY CONTACT INFORMATION

Notify: _____ Phone: _____
Relationship to Client: _____ OK to contact: Y N (circle one)
By circling Yes, you are consenting to this person being called in the event of an emergency and waiving your right to confidentiality for such purposes.

HEALTH & MEDICAL INFORMATION

Primary Care Physician: _____ Phone:_____
Psychiatrist: _____ Phone:_____
Please list any current medical problems: _____
_____
Please list any current medications you are taking or have been prescribed (including dosages):_____
_____

MENTAL HEALTH INFORMATION

Have you previously seen a counselor/psychiatrist/psychologist? Yes No
Who/When? _____
Have you previously attempted suicide? Yes No
Have you previously been hospitalized for mental health issues? Yes No
Have you ever been treated for substance abuse? Yes No
Where/When? _____
Have you experienced sexual, physical, emotional abuse in your lifetime? Yes No
Explain: _____

FOR OFFICE USE ONLY

CLIENT ID _____

Symptom Assessment:

(Please give as accurate an account as possible, and if you have questions, we can discuss them during your intake appointment).

I am experiencing…	Always	Often	Seldom	Never	For how long?
Frequent worry or tension					
Fear of many things					
Discomfort in social situations					
Feelings of guilt					
Phobias: unusual fears of specific things					
Panic attacks/shortness of breath/chest pains					
Recurring, distressing thoughts about a trauma					
"Flashbacks," as if reliving a traumatic event					
Avoiding specific places/things/events					
Nightmares					

I am feeling…	Always	Often	Seldom	Never	For how long?
Decreased interest in pleasurable activities					
Social isolation, loneliness					
Suicidal thoughts					
Bereavement or feelings of loss					
Changes in sleeping habits					
Changes in appetite or eating habits					
Normal/daily tasks require more effort					
Sad, hopeless about future					
Excessive feelings of guilt					
Low self-esteem					

I notice…	Always	Often	Seldom	Never	For how long?
I am angry, irritable, hostile					
I feel euphoric, energized, and highly optimistic					
I have racing thoughts					
I need less sleep than usual					
I am more talkative					
My mood fluctuates (goes up and down)					

I have…	Always	Often	Seldom	Never	For how long?
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tell me					
Intrusive or strange thoughts					
Obsessive thoughts					
Seeing or hearing things others can't					
Problems with my speech					
Risk taking behaviors					
Compulsive or repetitive behaviors					
Been acting without concern for consequence					
Been physically harming myself					
Been violent toward other(s)					

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I use the following…	Always	Often	Seldom	Never	For how long?
Alcohol					
Nicotine					
Marijuana					
Cocaine					
Opiates					
Sedatives					
Hallucinogens					
Stimulants					
Methamphetamines					
Other drugs _____					

My eating involves…	Always	Often	Seldom	Never	For how long?
Restriction of food consumption					
Bingeing and purging					
Binge eating					
A lot of weight loss or gain					

I have…	Always	Often	Seldom	Never	For how long?
Concerns about my sexual functioning					
Discomfort engaging in sexual activity					
Questions about my sexual orientation					
Difficulty discussing my sexual needs with my partner(s)					

Employment & Self Care	Always	Often	Seldom	Never	For how long?
I have problems getting/keeping a job					
I have problems paying for basic expenses					
I have fears of becoming homeless					
I have problems accessing healthcare					

Personal & Family History

Have you or *a close relative* ever been hospitalized for a psychiatric reason? If yes, please explain.

_____

_____

Have you or *a close relative* ever attempted suicide? If yes, please explain.

_____

_____

Have you or *a close relative* ever been diagnosed with a mental disorder? If yes, please explain.

_____

_____

Have you or *a close relative* ever had a substance abuse problem? If yes, please explain.

_____

_____

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