

LWR THERAPY REGISTRATION FORM

INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. Please fill out this form before your first session.

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

Address: _____
(Street and Number)

(City) (State) (Zip)

Birth Date: ____/____/____ Age: ____ Gender: ☐ Male ☐ Female ☐ Transgender

Ethnicity: _____ (optional) Primary Language: _____

Referred by (if any): _____

Name of parent/guardian, if applicable. Relationship to client: _____

(Name) (Phone)

Marital Status:

☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Please list any children and age: _____

Home Phone: (____) ____ - ____

May I leave a message? ☐ Yes ☐ No

Cell Phone: (____) ____ - ____

May I leave a message? ☐ Yes ☐ No

May I leave a text message? ☐ Yes ☐ No

Email: _____

May I email you? ☐ Yes ☐ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: (____) ____ - ____

THERAPY GOALS

What do you consider to be some of your strengths?

What do you consider to be some of your challenges or needs?

What would you like to accomplish out of your time in therapy?

PRIOR TREATMENT

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? ☐ No ☐ Yes

If yes, previous therapist/practitioner: _____
(Name and phone number)

When and for how long? _____

What was the focus of treatment? _____

Are you currently taking any psychiatric medication? ☐ Yes ☐ No

If yes, please list: _____

Are you currently taking any other prescription medication? ☐ Yes ☐ No

If yes, please list: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current sleeping habits? (please check)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific sleep problems you are currently experiencing:

2. How would you rate your current physical health? (please check)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific health problems you are currently experiencing:

3. How many times per week do you generally exercise? _____
What types of exercise do you participate in: _____

4. Describe any changes to your appetite in the last three months?
☐ Eating less ☐ Eating more ☐ Purging ☐ No change

Please list any difficulties you experience with your appetite/eating patterns, or past eating disorders:

5. Are you currently experiencing any chronic pain? ☐ Yes ☐ No
If yes, please describe? _____

6. Have you ever experienced sadness, grief or depression for an extended period? ☐ Yes ☐ No
If yes, when and for approximately how long? _____

7. Have you ever experienced excessive anxiety, panic attacks or have any phobias? ☐ Yes ☐ No
If yes, when did you begin experiencing this? _____

8. Have you ever experienced mania (euphoria, rapid speech, risky impulsive acts)? ☐ Yes ☐ No
If yes, when did you begin experiencing this? _____

9. Have you ever experienced any hallucinations or delusions? ☐ Yes ☐ No
If yes, when did you begin experiencing this? _____

10. Have you ever struggled with alcohol or substance abuse? ☐ Yes ☐ No
If yes, for how long and are you in recovery? _____

11. Do you currently use alcohol? ☐ Yes ☐ No
If yes, how many times per week and how much? _____

12. Do you currently recreational drugs or non-prescribed prescription drugs? ☐ Yes ☐ No
If yes, what type, how many times per week and how much? _____

13. Are you experiencing any other addictive behaviors? ☐ Yes ☐ No
If yes, what kind and how is it a problem? _____

14. Are you currently in a relationship? ☐ Yes ☐ No
If yes, for how long? _____ On a scale of 1-10, how would you rate your relationship? _____

15. Are you currently experiencing any suicidal thoughts or have in the past? ☐ Yes ☐ No
If yes, please provide time frame and severity? _____

16. Are you currently experiencing any homicidal thoughts or have in the past? ☐ Yes ☐ No
If yes, please provide time frame and severity? _____

17. Are you currently experiencing incidents of self-harm or have in the past? ☐ Yes ☐ No

If yes, please provide time frame and severity? _____

18. Please identify any current and past trauma experiences (e.g., physical, emotional or sexual abuse; major accidents or natural disasters) and provide time period of trauma incident(s).

19. What significant life changes or stressful events have you experienced in the last year?

20. Are you currently working or in school? ☐ Yes ☐ No

If yes, what is your job/studies? Do you enjoy your job/school? Is there anything particularly stressful about your job/school?

21. Any other clinical issues or significant events that you would like me to know about?

FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

List Family Member(s), including yourself

ADHD	☐ Yes ☐ No
Alcohol/Substance Abuse	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No
Bipolar	☐ Yes ☐ No
Depression	☐ Yes ☐ No
Domestic Violence	☐ Yes ☐ No
Eating Disorders	☐ Yes ☐ No
Obesity	☐ Yes ☐ No
Obsessive Compulsive Behavior	☐ Yes ☐ No
Schizophrenia	☐ Yes ☐ No
Suicide Attempts	☐ Yes ☐ No

CBT Skill Acquisition (CBTSA)

Unique Client ID: _____

Pre Evaluation ☐

Post Evaluation ☐

Date Completed: ____ / ____ / ____

Sessions Completed: _____

Program Name: _____

Facilitator: _____

Instructions: Please circle the number that best describes *how much you actually* do the following things:

	I don't know what this means	I don't do this	I do this a little	I sometimes do this	I mostly do this	I always do this
1. Plan activities for free time.	0	1	2	3	4	5
2. Identify beliefs and behaviors that make my situation worse.	0	1	2	3	4	5
3. Identify risk factors for returning to criminal behavior.	0	1	2	3	4	5
4. Engage in a positive activity instead of a behavior that is harmful to me or others.	0	1	2	3	4	5
5. Purposefully do fun things I like when I am feeling badly.	0	1	2	3	4	5
6. Catch myself when I jump to conclusions.	0	1	2	3	4	5
7. Notice when I start to feel more distressed.	0	1	2	3	4	5
8. Challenge my thoughts.	0	1	2	3	4	5
9. Motivate myself by doing things.	0	1	2	3	4	5
10. Socialize even though I don't feel like it.	0	1	2	3	4	5
11. Plan my time during the week.	0	1	2	3	4	5
12. Identify stressors that led me into criminal behavior.	0	1	2	3	4	5
13. Communicate my needs effectively.	0	1	2	3	4	5
14. Catch my negative thought patterns at the time that I have them.	0	1	2	3	4	5
15. Keep track of signs and symptoms of re- turning to old habits.	0	1	2	3	4	5
16. Find evidence to support my thoughts before buying into them.	0	1	2	3	4	5
Totals:						

Getting Started Interactive Journal

Unique Client ID: _____

Pre Evaluation ☐

Post Evaluation ☐

Date Completed: ____ / ____ / ____

Sessions Completed: _____

Program Name: _____

Facilitator: _____

Instructions: Please circle the number that best describes *how much you actually* do the following things:

	I don't know what this means	I don't do this	I do this a little	I sometimes do this	I mostly do this	I always do this
17. Understand my role and what to expect during the time I spend under supervision.	0	1	2	3	4	5
18. Recognize unique challenges that might get in the way of my supervision success.	0	1	2	3	4	5
19. Identify specific areas I want to focus on as I work with my support team and make plans for change.	0	1	2	3	4	5
Total:						

Responsible Thinking Interactive Journal

Unique Client ID: _____

Pre Evaluation ☐

Post Evaluation ☐

Date Completed: ____ / ____ / ____

Sessions Completed: _____

Program Name: _____

Facilitator: _____

Instructions: Please circle the number that best describes *how much you actually* do the following things:

	I don't know what this means	I don't do this	I do this a little	I sometimes do this	I mostly do this	I always do this
20. Weigh the long-term costs of negative behavior against the short-term payoffs.	0	1	2	3	4	5
21. Identify possible errors in my thinking and replace them with more positive beliefs and self-talk.	0	1	2	3	4	5
22. Apply the stepwise approach of problem solving to situations in my life.	0	1	2	3	4	5
Total:						

Self-control Interactive Journal

Unique Client ID: _____

Pre Evaluation ☐

Post Evaluation ☐

Date Completed: ____ / ____ / ____

Sessions Completed: _____

Program Name: _____

Facilitator: _____

Instructions: Please circle the number that best describes *how much you actually* do the following things:

	I don't know what this means	I don't do this	I do this a little	I sometimes do this	I mostly do this	I always do this
23. Identify feelings that put me at risk and bring on actions that create problems for me and others.	0	1	2	3	4	5
24. Recognize signals my body gives me as a first step in handling uncomfortable feelings.	0	1	2	3	4	5
25. Have a self-control strategy to manage difficult situations in my life.	0	1	2	3	4	5
Total:						

Recreation & Leisure Interactive Journal

Unique Client ID: _____

Pre Evaluation ☐

Post Evaluation ☐

Date Completed: ____ / ____ / ____

Sessions Completed: _____

Program Name: _____

Facilitator: _____

Instructions: Please circle the number that best describes *how much you actually* do the following things:

	I don't know what this means	I don't do this	I do this a little	I sometimes do this	I mostly do this	I always do this
26. Know and apply four strategies that can help me overcome challenges in using my free time in responsible ways.	0	1	2	3	4	5
27. Identify activities to engage my mind, body and spirit.	0	1	2	3	4	5
28. Make a detailed plan for spending my free time in healthy, fun ways.	0	1	2	3	4	5
Total:						

Social Values Interactive Journal

Unique Client ID: _____

Pre Evaluation ☐

Post Evaluation ☐

Date Completed: ____ / ____ / ____

Sessions Completed: _____

Program Name: _____

Facilitator: _____

Instructions: Please circle the number that best describes *how much you actually* do the following things:

	I don't know what this means	I don't do this	I do this a little	I sometimes do this	I mostly do this	I always do this
29. Explore my positive, healthy values and what behaviors show these values.	0	1	2	3	4	5
30. Understand the positive lifestyle values of being honest, tolerant, caring, respectful and responsible and how these values fit with my goals for positive change.	0	1	2	3	4	5
31. Identify strategies to manage roadblocks to adopting positive values.	0	1	2	3	4	5
Total:						

Substance Use Interactive Journal

Unique Client ID: _____

Pre Evaluation ☐

Post Evaluation ☐

Date Completed: ____ / ____ / ____

Sessions Completed: _____

Program Name: _____

Facilitator: _____

Instructions: Please circle the number that best describes *how much you actually* do the following things:

	I don't know what this means	I don't do this	I do this a little	I sometimes do this	I mostly do this	I always do this
32. Recognize negative consequences I have experienced as a result of my alcohol/other drug use.	0	1	2	3	4	5
33. Explore my strengths and how they can help me achieve my goals related to changes in substance use.	0	1	2	3	4	5
34. Develop a detailed plan to help me manage my recovery.	0	1	2	3	4	5
Total:						

Family Ties Interactive Journal

Unique Client ID: _____

Pre Evaluation ☐

Post Evaluation ☐

Date Completed: ____ / ____ / ____

Sessions Completed: _____

Program Name: _____

Facilitator: _____

Instructions: Please circle the number that best describes *how much you actually* do the following things:

	I don't know what this means	I don't do this	I do this a little	I sometimes do this	I mostly do this	I always do this
35. Acknowledge changes I would like to see in my family relationships.	0	1	2	3	4	5
36. Practice healthy ground rules to improve family relationships.	0	1	2	3	4	5
37. Develop an action plan to improve family relationships.	0	1	2	3	4	5
Total:						

Peer Relationships Interactive Journal

Unique Client ID: _____

Pre Evaluation ☐

Post Evaluation ☐

Date Completed: ____ / ____ / ____

Sessions Completed: _____

Program Name: _____

Facilitator: _____

Instructions: Please circle the number that best describes *how much you actually* do the following things:

	I don't know what this means	I don't do this	I do this a little	I sometimes do this	I mostly do this	I always do this
38. List important relationships that will likely support my efforts toward making positive behavior changes.	0	1	2	3	4	5
39. Practice effective communication skills using the three elements of communication.	0	1	2	3	4	5
40. Practice handling social pressure by using the four elements of an effective response.	0	1	2	3	4	5
Total:						

Seeking Employment Interactive Journal

Unique Client ID: _____

Pre Evaluation ☐

Post Evaluation ☐

Date Completed: ____ / ____ / ____

Sessions Completed: _____

Program Name: _____

Facilitator: _____

Instructions: Please circle the number that best describes *how much you actually* do the following things:

	I don't know what this means	I don't do this	I do this a little	I sometimes do this	I mostly do this	I always do this
41. Identify my strongest interests and how these interests link to potential jobs.	0	1	2	3	4	5
42. Set specific tasks to achieve job search activities within a doable time frame.	0	1	2	3	4	5
43. Recognize barriers to employment and outline what I can do to overcome each one.	0	1	2	3	4	5
Total:						

Scoring

Unique Client ID: _____

Pre Evaluation ☐

Post Evaluation ☐

Date Completed: ____ / ____ / ____

Sessions Completed: _____

Program Name: _____

Facilitator: _____

Instructions: Please circle the number that best describes *how much you actually* do the following things:

	Participant's Points	Possible Points
CBTSA		80
Getting Started		15
Responsible Thinking		15
Self-control		15
Recreation & Leisure		15
Social Values		15
Substance Use		15
Family Ties		15
Peer Relationships		15
Seeking Employment		15
Total:		

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date _____ Patient Name: _____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	☐ 0	☐ 1	☐ 2	☐ 3
2. Feeling down, depressed, or hopeless.	☐ 0	☐ 1	☐ 2	☐ 3
3. Trouble falling or staying asleep, or sleeping too much.	☐ 0	☐ 1	☐ 2	☐ 3
4. Feeling tired or having little energy.	☐ 0	☐ 1	☐ 2	☐ 3
5. Poor appetite or overeating.	☐ 0	☐ 1	☐ 2	☐ 3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	☐ 0	☐ 1	☐ 2	☐ 3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	☐ 0	☐ 1	☐ 2	☐ 3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	☐ 0	☐ 1	☐ 2	☐ 3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	☐ 0	☐ 1	☐ 2	☐ 3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all

Somewhat difficult

Very Difficult

Extremely Difficult

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

GAD-7	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	☐ 0	☐ 1	☐ 2	☐ 3
2. Not being able to stop or control worrying.	☐ 0	☐ 1	☐ 2	☐ 3
3. Worrying too much about different things.	☐ 0	☐ 1	☐ 2	☐ 3
4. Trouble relaxing.	☐ 0	☐ 1	☐ 2	☐ 3
5. Being so restless that it's hard to sit still.	☐ 0	☐ 1	☐ 2	☐ 3
6. Becoming easily annoyed or irritable.	☐ 0	☐ 1	☐ 2	☐ 3
7. Feeling afraid as if something awful might happen.	☐ 0	☐ 1	☐ 2	☐ 3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all

Somewhat difficult

Very Difficult

Extremely Difficult

Preparing for a Therapy Appointment

Getting the Most Out of Therapy:

Before you go to see a therapist or doctor about a behavioral health or substance use issue, it may help to know what to expect. We've put together some notes and suggestions to help you prepare for your first appointment and get the most out of therapy.

Preparing For the First Appointment:

When you meet your therapist for the first time it is easy to get confused or forget important information. Writing a few notes to take with you can help. These might include:

- What do you hope to accomplish by going to therapy?
- How would you like things to be different at the end of therapy?
- What has been happening in your life that leads you to go to therapy? How long has this been happening and how troubling is it?
- How have you been feeling? Are you experiencing nervousness, depression or other emotions that are troubling?
- What have you done to try to feel better? What has made you feel better in the past?
- Who else have you seen about this problem, including another therapist, your doctor, a clergy or rabbi, or support groups such as AA?

- Bring a list of all medicines you are taking for both physical and behavioral health reasons. Include name, dose, frequency, and any side effects you are experiencing. Bring along contact information for all doctors who are giving you medicine.
- Bring copies of any documents you think might be helpful. These include previous psychological testing, hospital discharge summaries, or recent laboratory results. If you are bringing your child in for therapy, then bring copies of recent school progress reports and psychological testing results.
- Bring a list of any questions you have about how therapy works, including frequency, cost, and what you will need to do. Ask if you will have things you need to do between appointments.
- If you would like, ask if you can include your family or social support in some of the sessions.

The First Appointment:

Try to arrive 15 minutes early for the first appointment to complete paperwork. Appointments usually last 30-50 minutes. You and the therapist will use the first appointment or two getting to know each other and deciding if the therapist can help you.

During your first meeting with a therapist, you can expect . . .

- To be asked to complete some forms. These will likely ask for information about yourself, your insurance coverage, and about what you are currently going through. You should also be given a statement of the therapist's privacy policy and a statement about your rights and responsibilities in therapy.
- To be asked some questions about yourself and what brought you to therapy. Answer in your own words or bring out the notes you wrote before the first appointment. Be as clear and thorough as you can be so that the therapist can help you.
- At the end of the session, to talk with the therapist about a plan to help you. This may include continuing to meet with the therapist on a regular basis, or the therapist may refer you to another specialist who may be better able to help you. If your therapist recommends that you continue to

come to appointments, you should have a clear idea of what to expect to happen during those appointments.

- To feel listened to and comfortable talking with the therapist. You should feel free to express yourself and talk about what is important to you. If you do not, let the therapist know so that you can discuss what to do about it.

If you Need Medicine:

Some behavioral health and substance abuse issues are also treated with medicines. You may be asked to see a Doctor or Nurse Practitioner who can prescribe you medicine. When you meet with this person, it is important to talk to your doctor or nurse practitioner about:

- Any other medicines you are taking.
- Any allergies you have to medicines.
- Medicines you have taken in the past and whether they have helped you.
- Medicines that have been helpful to any other family members who have had the same problems.
- Any side effects you have once you start the medicine.
- Any positive effects you have once you start the medicine.
- Any problems in paying for your medication?

It is very important to be open and honest with your doctor or nurse practitioner so that he/she can make decisions with you about the best medicine for you. There are no lab tests that can be done to find the ideal medicine for you, so your doctor or nurse can only make decisions based on what you report.

Below are some other things to keep in mind when getting help:

Take an Active Role

- Keep your appointments.
- Ask questions.
- Request that your doctors all work together.

Sooner the better

- Go to appointments as often as recommended.
- Appointments may be more often when you start treatment.