### Joy B. Krumenacker, LPC, NCC 575 Allegheny Ave Oakmont, PA 15139 412-501-3281

## **Intake and Background Information**

NAME	_D.O.B	_//	AGE:		
ADDRESS:					
PRIMARY PHONE:SECO	ONDARY PHO	)NE:			
May we contact you on either number?		_Leave messages?			
EMAIL ADDRESS:					
Do you elect to receive correspondence from our and general announcements? Yes No		email such	as newslette	rs, events,	
OCCUPATION: Employed Student Uner	mployed I	Retired	Military	Other	
RELATIONSHIP STATUS: Single Partnered	Domestic Par	tnership	Married		
Divorced/Separated Widowed Other					
EMERGENCY CONTACT:	PHONE	E:			
RELATIONSHIP (of emergency contact) TO YOU					
Are you currently under another professional's capsychological/mental health counseling? YES	are for psycho NC		any other ty	pe of	
Have you had counseling/psychological services	in the past? If	f yes, with v	who and dur	ation.	

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Who referred you to Inner Balance?
What concerns brought you to counseling?
What are you hoping to achieve by attending counseling sessions?

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## **Symptom Questionnaire:**

Over the past 2 weeks, how often have you been bothered by any of the following?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, hopeless				
Trouble falling or staying asleep				
Sleeping too much/too little (please circle one or both)				
Loss of appetite and/or weight loss/weight gain (please circle one or both, or all three)				
Overeating/not eating enough/lack of appetite (please circle one, or both, or all three)				
Feeling bad about yourself/worthlessness				
Trouble with concentration				
Thoughts of killing or harming yourself				
Feeling sluggish, lethargic				
Feeling fidgety, restless				
High levels of energy				
Pressure to keep talking				
Relationship/interpersonal stressors				
Time management problems				
Physical pain				
Loss of control				
Drinking/substance use (please circle one or both)				

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Have you experienced feelings of fear or panic over the past four weeks? Yes					
If yes, has this ever happened before?		No			
Do these attacks come on suddenly/unexpectedly?		No			
Does fear of another attack worry you or prevent you from doing things? Yes					
During an attack, do you experience shortness of breath, racing heartbeat, numbne nausea, or tingling?					
If you circled yes to any of these problems, or endorsed any of the above symptoms, how difficult have these problems made it for you to function daily (to do your work/school, take care of things at home, and/or get along with others?)					
Not difficult at all Somewhat difficult Very difficult	Extremely	y difficult			
Person(s) currently living in your home (name, age, relationship):					
Relevant medical issues/concerns:Significant medical history of relatives (parents, children, others);					
Current prescription/Over the counter medications and purposes:					
Relational/Intimacy/Sexual issues:					

Finally, is there any other concern, issue, or desire that had not yet been indicated that you would like to bring to our attention?