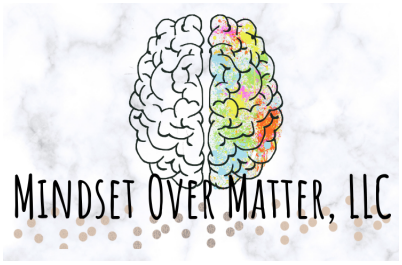


Benefit Information

(this is required to bill your insurance)

Primary Insurance Information

Insurance Policy Holder Name: _____ DOB: _____ SS#: _____

Policy Holder Place of Employment: _____

Insurance Type: _____

ID #:_____

Group #:_____

If insurance policy holder address is different than client's address please list it below:

_____

Street City State Zip

Policy Holder Signature: _____ Date _____

Secondary Insurance Information

Insurance Policy Holder Name: _____ DOB: _____ SS#: _____

Policy Holder Place of Employment: _____

Insurance Type: _____

ID #:_____

Group #:_____

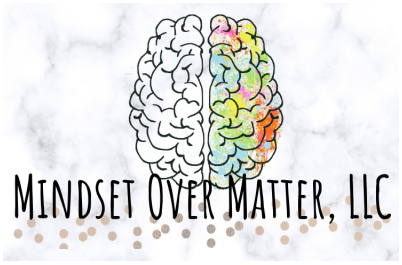
If insurance policy holder address is different than client's address please list it below:

_____

Street City State Zip

Policy Holder Signature: _____ Date _____

Brianne Orloff, LPC
17 Merline Ave, Ste 3 Erie PA 16509
814-230-2341 : mindsetovermatterllc@gmail.com



Initial Intake Assessment Form

Date: _____

Client Name: _____
(First) (Last)

Client DOB: _____ Age: _____ SSN _____

Gender Identity: _____ Gender Expression: _____

Race/Ethnicity: _____

Religion/Spirituality: _____

Parent/Guardian(s) (if under age 18): _____

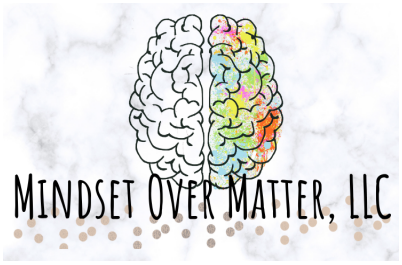
Client Address 1: _____
Street City State Zip

Client Address 2: _____
Street City State Zip

Primary Phone #: _____Ok to leave voicemails? Yes____ No____

Secondary Phone #: _____ Ok to leave voicemails? Yes____ No____

Emergency Contact: _____
(Name) (Phone)



Presenting concerns

Reason for treatment. Tell me what brings you to therapy:

_____

_____

_____

_____

How long has this been an issue or concern? _____

Strengths

Strengths of the client and/or family:

_____

_____

_____

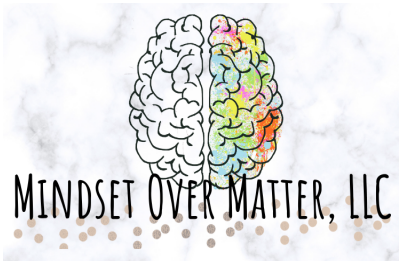
_____

Past Mental Health Treatment/History

(leave blank if none)

Place/Facility	Dates/How old were you	Reason

Additional:



Family Mental Health Treatment/History (immediate and extended family members):

Person	Mental Health Concern(s)

Additional:

How has mental health in the family affected you?:

_____

_____

_____

_____

Medical History

Current Medications (leave blank if none)

Medicine Name	Dosage/Frequency	How long have you been taking this?

Additional medications: _____

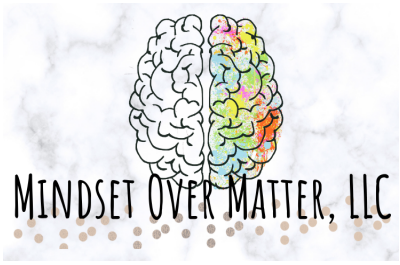
_____

Have you taken past medications? Were they effective? (leave blank if not applicable)

_____

_____

Medication Allergies? No_____ Yes (explain) _____



Primary Care Physician Information:

Name**:** _____

Address/Phone _____

Current Medical Conditions? No_____ Yes _____ If yes, please explain below.

_____

_____

Substance Use/Treatment History

Do you currently :

-Smoke? No____ Yes____ If yes how much/often _____

-Drink alcohol? No_____ Yes_____ If yes how much/often _____

-Use illicit substances? No____ Yes_____ If yes, what/how often_____

Have you ever been to a rehabilitation facility for drugs/alcohol? No____ Yes_____ If yes please explain where, when, for what, length of stay: _____

_____

Trauma/Abuse History

Have you been the *victim to* any type of abuse (physical, sexual, mental/emotional) or neglect?

No_____ Yes_____ (explain)

_____

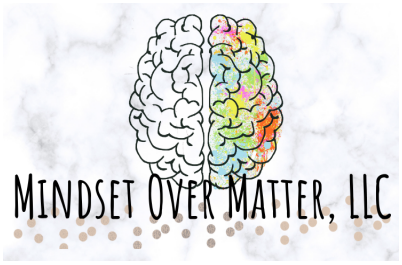
Was legal action taken? _____

Have you been the *perpetrator of* any type of abuse (physical, sexual, mental/emotional) or neglect?

No_____ Yes_____ (explain)

_____

Was legal action taken? _____



Have you experienced any of the following (check all that apply):

_____ Frequent moves or house/school changes
_____ Witness to violence
_____ Witness to a death
_____ Household member substance abuse. Who _____
_____ Placement (residential treatment facility, partial placement)
_____ Death of family member or friend whom you considered close
_____ Household fire
_____ Significant parent illness
_____ Domestic violence (witness or victim to)
_____ Significant injury or illness (medical, serious accident)
_____ Any other life event you would consider traumatic? Please explain:

_____

_____

Please complete the ACES assessment following this page

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

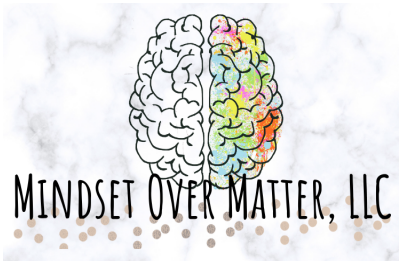
7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score



Family Dynamics

Domestic Relationships Status: _____ Single _____ Separated _____Divorced/Divorcing

_____Widowed _____ In a committed relationship. For how long? ____

-How would you describe this relationship? Circle all that apply

Loving/Supportive *Stressful/Chaotic* *Unhealthy* *Violent*

Co-dependent *Controlling* *Healthy* *Other:*

Do you have children? ____ No ____ Yes. How many _____

Childhood Information:

How would you describe your childhood upbringing/living environment?

_____

_____

_____

Do you have siblings? ____ No ____Yes. How many/what order are you? _____

_____

Growing up, what was the status of your parents/guardians? (circle) *Together* *Separated*

Divorced *Never together*

Other

Legal Information

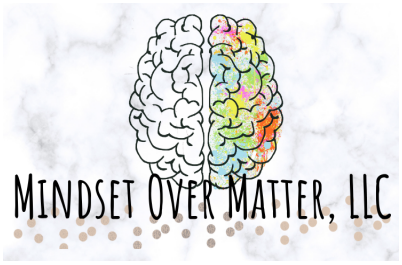
Legal Charges

Have you ever been charged with committing any crime or offense ____ No _____Yes. Explain:

_____

Are you currently on probation/house arrest? ____ No _____Yes. Explain: _____

_____



Education/Employment

What is your highest level of education completed?_____

If attending: What school/grade? _____

Are you employed? ____No

_____ Yes _____ Part-time _____ Full-time

Where/occupation? _____

Miscellaneous

(If you are filling this out for your child, make answers applicable to your child)

Do you participate in extracurricular sports, groups, activities, etc? _____ No _____Yes. Explain:

Support People- please list support systems you have: _____

_____

Sleep Pattern- Circle all that apply:

trouble falling asleep trouble staying asleep sleeping too much

sleeping too little frequent nightmares bed-wetting

Eating Habits-Circle all that apply:

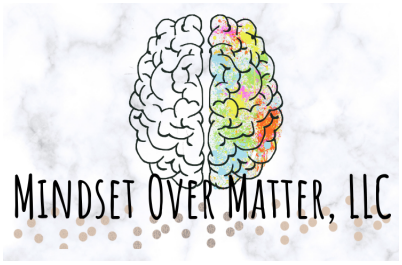
I often over eat I often under eat binge eating purging

I eat relatively healthy I eat unhealthy most times

Energy Level- Circle all that apply:

I feel like I have none I have way too much energy most of the time

I lost energy I once had I have a healthy amount of energy



Behavior Checklist

Please circle all that you identify yourself with. If you are filling this out for your child, please circle all that apply for your child.

Short temper	Low frustration tolerance
Anger outbursts	Impulsive
Lying/sneakiness	Frequent mood swings
Crying spells	Feeling like people are always out to get me
Hyperactive	Hard to take responsibility for my actions
Thoughts of self-harm	Missing a lot of work/Truancy issues
Acts of self-harm	No/little support system
Authority conflicts	Hopelessness
Helplessness	Isolating behaviors
Lack of motivation	Frequent job changes
Disassociation	Low self-esteem
Poor peer relationships	Bullying: _____victim of _____bullier
Property destruction	Frequent domestic relationship changes
Inattentive	Frequent body pains (headache, stomachache, etc)
Other: please list	