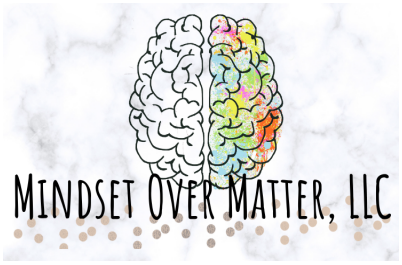



## Benefit Information

**(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 #:_____

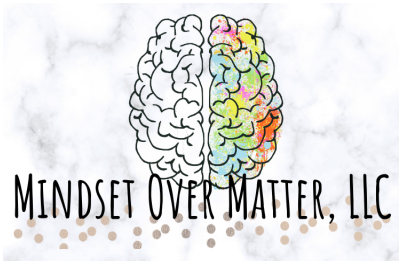
If insurance policy holder address is different than client's address please list it below:

_____

Street City State Zip

Policy Holder Signature: _____ Date _____

Brianne Slaney, 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): _____

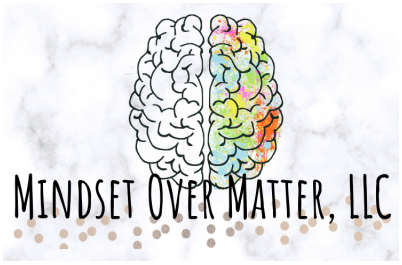
Client Address 1: _____
Street City State Zip

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:**

_____

_____

_____

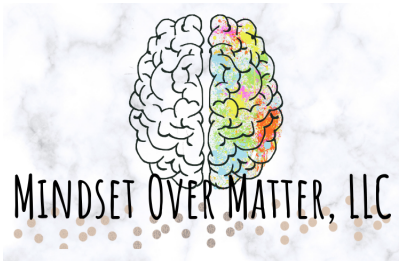
_____

## 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:** _____

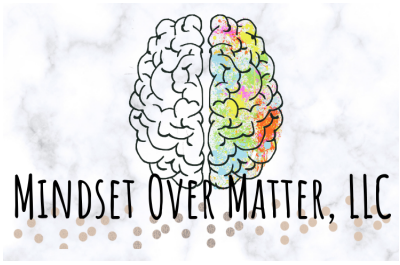
_____

**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)

_____

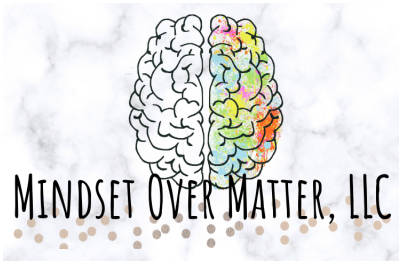
Was legal action taken? _____

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 _____

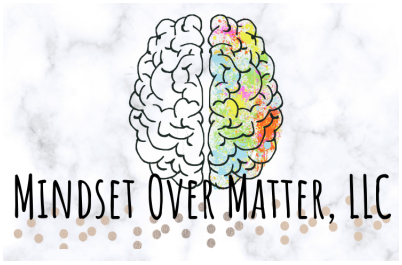
7. Was your mother or stepmother:
   **Often** pushed, grabbed, slapped, or had something thrown at her?
   **or**
   **Sometimes or often** kicked, bitten, hit with a fist, or hit with something hard?
   **or**
   **Ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?
   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

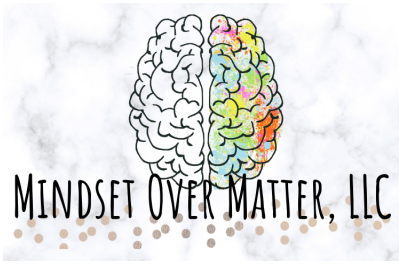
**Legal Charges**

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:

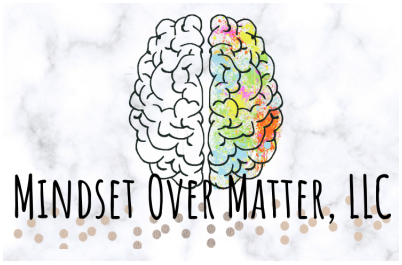
I often over eat  I often under eat  binge eating  purging

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 | |