

DELMORE COUNSELING, LLC

One Crosswoods Bldg · 100 East Campus View Blvd., Suite 155 · Columbus, Ohio 43235

Client Name: _____

Street Address: _____ City/State/Zip: _____

Home Phone #: _____ Can we call or leave a message at this number? Yes No

Daytime Phone #: _____ Can we contact you here? Yes No

Cell Phone #: _____ Can we call or leave a message on this phone? Yes No

Email Addresses: _____

Client Date of Birth: _____ Age: _____ Social Security #: _____

Responsible Party Name: _____

Emergency Contact Name: _____ Phone #: _____

Referral Source: _____

Services rendered by Dr. Janice L. Craig MD will be on a fee for service basis. You can submit these sessions to your insurance for reimbursement but Delmore Counseling, LLC will not be responsible for doing so. Our billing department can provide you with a billing code, diagnosis, and date of service form that will assist you with that process if you chose to submit to insurance. Dr. Craig's services are to be paid in full each session.

Dr. Janice L. Craig's fee schedule is as follows:

- **Initial Evaluation Session - \$300.00 per hour. Initial evaluations can last anywhere from 1 – 1.5 hours in duration.**
- **1 Hour Medication Management Session - \$300.00**
- **½ Hour Medication Management Session - \$150.00**

CLIENT AGREEMENT:

The above information is current and correct to the best of my knowledge. I understand that Dr. Craig's session will be required to be paid in full at time of service. Delmore Counseling, LLC accepts most major credit cards, cash, or checks as form of payment.

Client Name (please print)

Client Signature

Date

Responsible Party Name

Responsible Party Signature

Date

Witness

Date

DELMORE COUNSELING, LLC

One Crosswoods Bldg · 100 East Campus View Blvd., Suite 155 · Columbus, Ohio 43235

Adult Client Intake Form

Instructions: To assist us in helping you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to you, please leave them blank.

Identifying Information

Name: _____ Date of Birth: _____ Age: _____
Gender: Male Female Race: _____ Height: _____ Weight: _____ (optional)
Hair Color: _____ Eye Color: _____

Behavioral Health

Why are you seeking a medication evaluation?

What issues or circumstances do you believe contribute to your problems?

How long has this problem persisted?

Under what conditions do the problems usually get worse?

Under what conditions do the problems usually improve?

Have you previously been involved in counseling? No Yes If yes, describe the reasons for counseling and who provided the counseling.

Counselor:

Reason:

Outcome:

List your strengths:

List your weaknesses:

Psychiatric Hospitalizations: None Past Current

Dates of Service:	# of Days	Where & Reason (suicidal, depressed etc.)
-------------------	-----------	---

Dates of Service:	# of Days	Where & Reason (suicidal, depressed etc.)
-------------------	-----------	---

Behavioral Health Symptom Checklist

DELMORE COUNSELING, LLC

One Crosswoods Bldg · 100 East Campus View Blvd., Suite 155 · Columbus, Ohio 43235

Please indicate the degree to which you have experienced any of the following symptoms in the last 4 weeks.

0 = Never 1 = Occasionally 2 = Regularly 3 = Frequently

- _____ 1. Trembling, or feeling shaky
- _____ 2. Shortness of breath or smothering sensation
- _____ 3. Racing heart, heart palpitations or chest pain (circle which)
- _____ 4. Moist palms or excessive sweating
- _____ 5. Dizziness, lightheadedness, unsteady or faint (circle which)
- _____ 6. Nausea, diarrhea, or other abdominal distress (circle which)
- _____ 7. Frequent headaches or other muscle aches
- _____ 8. Startle easily
- _____ 9. Irritability (loses temper easily)
- _____ 10. Worrying a lot
- _____ 11. Trouble swallowing, "lump in throat", or choking sensation
- _____ 12. Fearful of or embarrassed by being watched or being the focus of attention
- _____ 13. Avoid talking to strangers
- _____ 14. Fear of embarrassment
- _____ 15. Persistent fear of an object (snakes) or situation (high places) considered excessive or unreasonable
- _____ 16. High levels of anxiety in the presence of an object or situation
- _____ 17. Regular and disturbing thoughts about a past traumatic experience
- _____ 18. Regular and disturbing dreams about a past traumatic experience
- _____ 19. Avoidance of thoughts feelings, or conversations associated with a traumatic experience
- _____ 20. Excessive hand washing or fear of germs
- _____ 21. Excessive checking (i.e., doors, locks, stove)
- _____ 22. Excessive need for order or neatness or counting ritual(s)
- _____ 23. Unusual and persistent sad feelings
- _____ 24. Diminished interest or participation in enjoyable or important activities
- _____ 25. Difficulty concentrating or poor memory (circle which)
- _____ 26. Tire easily or low energy level
- _____ 27. Thoughts of suicide
- _____ 28. Increased or decreased sleep (circle which): avg. hrs per night _____
- _____ 29. Feelings of hopelessness
- _____ 30. Persistent and abnormally elevated mood
- _____ 31. Over inflated feelings of self-worth
- _____ 32. Decreased need for sleep
- _____ 33. Rapid or racing thoughts
- _____ 34. Excessive involvement in pleasurable activities
- _____ 35. Excessive and/or reckless spending
- _____ 36. See or hear things that others around you are unable to perceive
- _____ 37. Hold ideas or beliefs that are not shared by others
- _____ 38. Self induced vomiting
- _____ 39. Excessive exercise
- _____ 40. Use of laxatives or diuretics to lose weight
- _____ 41. Dieting (very strict, women consuming less than 1400 daily calories or men less than 2000 calories)
- _____ 42. Careless mistakes in school work, work, or other activities
- _____ 43. Can only pay attention for short periods at school/work/home
- _____ 44. Failure to complete schoolwork, chores, duties
- _____ 45. Hyperactive: fidgets, squirms, talks excessively
- _____ 46. Acts without thinking of consequences

DELMORE COUNSELING, LLC

One Crosswoods Bldg · 100 East Campus View Blvd., Suite 155 · Columbus, Ohio 43235

Drug and Alcohol History

Indicate the level of use for each substance by checking the appropriate box.

	No Use	Past use	Current Use		No Use	Past use	Current Use
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinogens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inhalants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hashish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stimulants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If current or past use is indicated to any of the above items complete the following questions?

Drug/Alcohol Type	Age of 1 st use	Date of last use	Frequency	Amount Used	Method <input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Nasal <input type="checkbox"/> Injection
Drug/Alcohol Type	Age of 1 st use	Date of last use	Frequency	Amount Used	Method <input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Nasal <input type="checkbox"/> Injection
Drug/Alcohol Type	Age of 1 st use	Date of last use	Frequency	Amount Used	Method <input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Nasal <input type="checkbox"/> Injection

Are you currently pregnant ? No Yes Are you an IV drug user? No Yes

Have you ever received inpatient drug and/or alcohol treatment? No Yes

If yes, When? _____ Where? _____

Have you ever received outpatient drug and/or alcohol treatment? No Yes

If yes, When? _____ Where? _____

Are you involved in any community self-help groups such as AA, NA No Yes

Family History

Marital status: Single Married Divorced Separated Widowed
 Living with a Significant Other but Never Married

If married: how long have you been married? _____ Spouse's age: _____

Are there presently experiencing any serious marital conflicts

No Yes If yes, explain: _____

If you have ever been divorced: How many times were you previously married? _____

Date of divorce(s) _____

Prior to the divorce(s), how long were you married? _____

Reasons for divorce(s) _____

Living Situation: Own Home Parent's Home Relative's Home Homeless Group Home
 Residential Other _____

Household members Names (if client lives in more than one household list household 1 – 2)	Relation to the Client	Age	Race	Occupation or School	Level of Education
Significant Family Members/Others not listed above:	Relation to the Client	Age	Race	Occupation or School	Level of Education

Briefly describe any problem areas that occur between you and people you live with:

DELMORE COUNSELING, LLC

One Crosswoods Bldg · 100 East Campus View Blvd., Suite 155 · Columbus, Ohio 43235

Please identify any of the following symptoms in the past 60 days? Please check.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Coughing | <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Memory Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Breathing Difficulty | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Tingling in Arms/Leg |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Falling | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Consciousness Loss | <input type="checkbox"/> Gait Unsteadiness | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Vision Changes |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Pulse Irregularity | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Other: _____ | | | |

Health History Questionnaire

Has the client **or any of the relatives (related by blood)** had any of the following health problems? If a blood relative has had the condition, please write down the relationship to the client (parent, brother/sister, aunts/uncles, cousins, children, etc.) in the comment section below.

Problem	Client			Family	Comment (Indicate family member relationship to client)
	Now	Past	Never	History	
AIDS					
Alcoholism					
Anemia					
Anxiety					
Arthritis					
Asthma					
Bipolar Disorder					
Bleeding Disorder					
Brain Tumor					
Cancer					
Cirrhosis					
Depression					
Diabetes					
Drug Abuse					
Eating Disorder					
Epilepsy/Seizures					
Eye Disease					
GI Problems					
Glaucoma					
Headaches					
Head Injury					
Hearing Problems					
Heart Disease					
Hepatitis					
High Blood Pressure					
Hyperactivity					
Jaundice					
Kidney Disease					
Learning Problems					
Lung Disease					
Low Blood Pressure					
Menstrual Pain					
Obsessive Compulsive Disorder					
Oral Health/Dental					
Schizophrenia					
Sexually Transmitted Disease					
Speech Problems					

DELMORE COUNSELING, LLC

One Crosswoods Bldg · 100 East Campus View Blvd., Suite 155 · Columbus, Ohio 43235

Have you ever been deployed to a combat zone? No Yes If yes, when? _____ Have you experienced any psychological or physical difficulties because of this deployment? No Yes explain? _____

Interests and Community Involvement

What meaningful activities, including leisure and recreational activities to you engage in?

What community activities, including volunteer work are you involved in?

What religious or spiritual activities do you participate in?

List any cultural or family traditions you have?

Legal History

Do you have a Legal Guardian/Custodian? No Yes If yes, Name: _____ Phone: _____

Civil Proceedings: _____ Current Past When? _____

Domestic Relations Court

(Custody, Protective Services, Restraining Orders): _____ Current Past When? _____

Child Support Enforcement Orders: _____

Job and Family Service Involvement with Family: _____

Caseworker assigned to Family: _____ Phone: _____

Juvenile Court Involvement (for Child Abuse, Neglect or Dependency): Current Past When? _____

Current Legal Status: None Awaiting Charges On Probation/Parole Conditional Release
 Outpatient Commitment Incarcerated
 Other: _____

Legal Charges: Juvenile No Yes If yes,

Felony Misdemeanor Charge: _____ Current Past When? _____

Felony Misdemeanor Charge: _____ Current Past When? _____

Legal Charges: Adult No Yes If yes,

Felony Misdemeanor Charge: _____ Current Past When? _____

Felony Misdemeanor Charge: _____ Current Past When? _____

Incarcerations:

From _____ To _____ Where _____ Conviction: _____

From _____ To _____ Where _____ Conviction: _____

Probation/Parole Officer: _____ Phone: _____

DELMORE COUNSELING, LLC

One Crosswoods Bldg · 100 East Campus View Blvd., Suite 155 · Columbus, Ohio 43235

To the best of my knowledge, all the information I have given is accurate. I understand the information contained in my chart that is maintained at Delmore Counseling, LLC, may not be released to anyone without my written consent, with these exceptions:

- If the law mandates disclosure
- If you have placed yourself or someone else in clear and imminent danger
- For the purposes of therapist supervision and/or consultation that falls within the ethical guidelines of the Social Work, Counseling, and Psychiatry Boards.

CLIENT'S SIGNATURE _____ **DATE** _____

PLEASE PRINT LAST NAME _____ **FIRST NAME** _____