Gary H. Plep, LCSW

Therapy Uptake Sheet

Please complete all pages.

Date _____

Referred by _____

Name _____

_____
Street City Zip

Telephone (Day) _____ (Evening) _____

E-mail address _____ @ _____

Birthdate _____ Age ____ Race _____ Religion raised in _____

❑ Please check this box if you will need a statement at the end of each month.

Employment

Place of employment _____

Job description _____

Monthly income _____ _____
Yourself Total family

How many does this support? _____ Social security number _____

Do you have medical insurance? _____ Name of plan _____

Education

Last grade completed _____ Special training _____

Person to contact in an emergency _____
Name Relationship

_____
Address City State Phone

Family History

Marital status _____ Previous marriages _____

_____

Number of children _____ Who currently lives in your household? _____

_____

_____

Family Data Information						
Name	**City of Residence**	**Age**	**If Deceased, Age/Year of Death**	**Marital Status**	**Occupation**	**How do you get along?**
Spouse						
Children						
Others Living in Household Now						
Father						
Mother						
Step Parents						
Sisters & Brothers (order of birth)						

Problem History

When was the last time you had a complete physical examination? _____

Any abortions or miscarriages? _____ If yes, when? _____

Are you currently under a doctor's care for any illness? _____

Describe _____

Are you currently taking any medication or drugs? _____

What kind and dosage (include non-prescription drugs and recreational drugs)? _____

_____

_____

Have you ever had counseling or therapy before? _____ When? _____

With whom? _____ Type of treatment _____

Results _____

What do you want from this consultation? _____

_____

_____

What symptoms do you have? _____

_____

_____

Check items that may apply to you currently					
	Headaches		Nightmares		Unable to work well
	Dizziness		Sexual problems		Can't get interested
	Stomach trouble		Financial problems		Drink excessively
	Bowel trouble		Depressed		Excessive use of drugs
	Feel tense		Panicky feelings		Unable to have a good time
	Irritable		Tremors or tics		Trouble concentrating
	Unusal thoughts		Always worried		Can't make friends
	Strange experiences		Unable to relax		Can't keep friends
	Weight change		Feel worthless		Feel apart from people
	Always tired		Can't make decisions		Fear things I shouldn't
	Can't go to sleep		Thoughts of suicide		Conflict within family
	Can't stay asleep		Ready to explode		Fear I will lose self control
	Other:				

How long has this been a problem? _____

_____

_____

Is it getting worse? _____ Better? _____ What changes have you noticed? _____

_____

_____

What do you think is causing the problem? _____

_____

_____

Have you had any legal problems? _____ If so, what kind? _____

_____

_____

Does anyone in your family, including yourself, drink too much? _____

_____

_____

Comments _____

_____

_____

_____

_____

_____

_____

_____