Catherine A. MacLennan, PhD, Licensed Psychologist (WA PY00003197)
Clinical and Forensic
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Intake History

Today's date: _____

Name _____ DOB: _____AGE:_____
first middle last

Phone _____ email (if you are okay being contacted via email) _____

Mailing Address: _____

Name _____ DOB: _____AGE:_____
first middle last

Phone _____ email (if you are okay being contacted via email) _____

Mailing Address: _____

You are participating in a psychological evaluation or therapy with Dr MacLennan.

Please ask your medical providers and mental health providers to forward your medical and counseling records to Dr MacLennan. Complete your provider's "*Release Your Medical Records form*", and ask them to send the records to:

Catherine A MacLennan PhD
PO BOX A, Omak WA 98841
Fax 509 463-4699

Do you have special needs? circle please if yes

reading	Mobility (e.g., wheelchair, walker, etc)
Vision	Communication (need a translator)
hearing	

What medications do you take now: _____

_____

Have you had any of the following? (check if yes and add any additional)

	Covid-19		Diabetes
	allergies		Emphysema/COPD
	anemia		Gastroesophageal reflux disease (GERD)
	anxiety		glaucoma
	arthritis		Heart murmur
	asthma		HIV/AIDs
	Blood transfusion		High cholesterol
	cancer		Hypertension/high blood pressure
	Clotting disorder		Kidney disease
	Congestive heart failure (CHF)		Myocardial infarction
	depression		Nerve/muscle disease
	Heart murmur		Osteoporosis
	Emphysema/COPD		Seizures
	Gastroesophageal reflux disease (GERD)		Sickle cell anemia
	glaucoma		Thyroid disease
			Tuberculosis

Do you get regular exercise? What _____

How often __ Daily __ 1-2 times per week __ 3 times per week ___ More than 30 minutes

Hobbies/leisure activities: _____

Do you feel unsafe now, or have you been harmed in a physical, emotional or sexual manner, in any relationship or recent encounter?
Describe: _____

In the past year, have you had two weeks or more during which you felt sad, blue or depressed or when you have lost all interest or pleasure in things that you usually care about or enjoyed?

Describe: _____

In the past year, have you had any major life changes or stresses that you feel have impacted your health?

Describe: _____

Problems or symptoms in the past month	None or a little of the time	Some of the time	Most or all of the time
1. Wake up at night or in the early morning, unable to return to sleep			
2. Very restless sleep			
3. Fatigue or loss of energy			
4. Decreased sex drive			
5. Unable to enjoy life.			
6. Withdrawn from others			
7. Strong thoughts about suicide			
8. Loss of appetite			
9. Memory problems, forgetfulness, poor concentration			
10. Feel irritable or easily frustrated			
11. Feel sad or hopeless			
12. Sleep a lot			
13. Sleep less (decreased need for sleep)			
14. Increased sex drive			
15. Increased energy			
16. unusually happy or energetic (maybe people say you are “manic”)			
17. Did things you wish you had not done, spent money, sex, drugs, etc			
18. Cannot get to sleep			
19. Nightmares about frightening things that have happened to you			
20. Thoughts while you are awake about frightening things that have happened to you			

Problems or symptoms during the past month	None or a little of the time	Some of the time	Most or all the time
21. Sudden episodes of nervousness or panic			
22. Fear of losing self-control			
23. Palpitations or rapid heart beat			
24. Shortness of breath			
25. Feel tense or anxious all day			
26. Feel very anxious in social situations			
27. Recurring, troubling, thoughts, images, impulses you can't get out of your mind			
28. Repetitive behaviors such as excessive hand washing, etc.			
29. Feel very confused about your thoughts			
30. Strange or bizarre thoughts			
31. Hallucinations, hear voices, or see things that aren't there			
32. Very odd experiences that others do not understand			
33. Feel ready to explode			
34. Thoughts about harming someone			
35. Excessive use of alcohol or drugs in past month?			
36. Unusual eating habits			
37. Weight loss in past month? YES NO How much			
38. Weight gain in the past month? YES NO How much			
39. Have you been trying to diet in last month		YES	NO
40. Have you used alcohol in the last month		YES	NO
41. Have you tried to cut down on use of alcohol in past month		YES	NO
42. Have you used drugs (non-prescription) in the past month		YES	NO
43. Have you tried to cut down on use of drugs in the past month		YES	NO

Substance Abuse (Alcohol, Drugs) History Checklist

Please circle anything you have ever used in your life.
When did you last use this substance (date of your last use or approximate age)?
What was your age (or approximate year) when you first used?
Comments: How much do you use now, or how much did you use?
Add other substances (drugs) you have used that are not on the list.

Substance circle if you ever used	If you have used in your life		
	your last use	age you started	comments
alcohol			
Marijuana cannabis, hash, THC			
Spice/K2 synthetic marijuana			
Methamphetamine Amphetamine speed			
crack- cocaine			
cocaine			
PCP			
"designer" drugs e.g., MDMA (Ecstasy), ketamine, GHB, Rohypnol. Bath salts (synthetic stimulant/cathinone). Flakka (alpha-PVP)			
Inhalants gas, glue, paint			
Psychedelics LSD, mushrooms, peyote			
Barbituates Tranquilizers. barbs, downers, Christmas trees, blue heavens, blues, pinks, rainbows, reds, red devils, sleepers, double trouble, yellow jackets			
Benzodiazepines valium, ativan			
Other			

Substance circle if you ever used	If you have used in your life		
	your last use	age you started	comments
Medications/drugs (circle any you have used)			
Opiates/opioids pain pills, narcotics, percocette, oxycodone, hydrocodone opium, morphine. Fentanyl, heroin			
Suboxone			
methadone			
tobacco			
caffeine			
Others			

Have you ever had any of the following (alcohol, drugs, medication)?

[ ] hangovers
[ ] withdrawal symptoms
[ ] sleep disturbance
[ ] binges
[ ] seizures
[ ] medical conditions
[ ] assaults
[ ] job loss
[ ] blackouts
[ ] tolerance changes
[ ] suicidal impulse
[ ] arrests
[ ] overdose
[ ] loss of control amount used
[ ] relationship conflicts

other:

[ ] Criminal charges related to drugs or alcohol
[ ] currently on probation
[ ] Pending court date
[ ] Feeling pressured by family to quit
[ ] Have you ever failed a drug test at work __ Y __ N for what/when: _____
[ ] Family member thinks I have a problem but I don't think I do. ____ Y ___ N

Is the place you live now as supportive as you need it to be for you to be successful?

____ Y ___ N Comments: _____

Have you ever been in treatment for alcohol/drugs? ____ Y ___ N

1. Inpatient - where & How many times_____
2. Outpatient – where & how many times _____

Do you want help now with alcohol and/or drugs? ____ Y ___ N

Comments: _____

_____

Did you experience any of the following in your childhood? (ACES)
Please check if yes, and explain

- ☐ Physical abuse
- ☐ Emotional abuse
- ☐ Sexual abuse
- ☐ Physical neglect
- ☐ Emotional neglect
- ☐ Domestic violence
- ☐ Parental substance abuse
- ☐ Household mental Illness
- ☐ Parental separation or divorce
- ☐ Suicide or death
- ☐ Crime or Imprisoned family

Have you ever seen Behavioral Health professionals, mental health professionals, counselors, therapists, psychologists __ yes __ no Please provide names, contact information, dates.

_____

_____

Have you ever been hospitalized for psychiatric or mental health care? __ yes __ no
Provide hospital names, contact information, approximate dates

_____

Please describe your current emotional or mental-health concerns

_____

_____

Has anything been helping you feel better, or maintain your mood?

How has COVID, the pandemic and the physical/social isolation affected you or changed your life, and your family life?

_____

_____

_____

Education? Last grade completed _____ GED _____ College _____

Did you have any problems with learning in school? Any problems with memory?

_____

Work history When did you last work? _____

What types of work have you done? _____

Please provide names, phone numbers, email for people who you think I should contact:

_____

_____

PCL-5

Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

Instructions: **In the past month, how much were you bothered by:**	**Not at all**	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being “superalert” or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4