**Chrysalis Intake**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_/\_\_\_/\_\_\_

*Communication* E-mail Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work or Cell Phone (circle) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your *Most Prominent* Difficulties For How Long?

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Describe how you were *before* those difficulties began?

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What symptoms have you had *throughout* your life?

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List your current medications, reasons for taking them, and their effects on you

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Current Past

(Y/N) (Y/N)

Unpredictable things have/had a big effect on me. \_\_\_\_\_ \_\_\_\_\_

Situations are/were embarrassing for me. \_\_\_\_\_ \_\_\_\_\_

Friends and/or family have/had a hard time being around me. \_\_\_\_\_ \_\_\_\_\_

I am/was troubled by emotions/feelings. \_\_\_\_\_ \_\_\_\_\_

I have/had *migraine, tics, seizures, and/or explosive episodes*. \_\_\_\_\_ \_\_\_\_\_

Please describe how you feel?

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What do you notice about yourself?

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What other modalities of help have you tried? When?

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How do you describe/define yourself?

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How will you know when you are done?

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How long have you been seeking resolution?\_\_\_\_\_\_\_\_\_\_