Blue Lotus Mental Health Counseling PLLC • Individual & Family Therapy Intake Form

PERSONAL INFORMATION Today's Date: _____ Preferred Session Day & Time: _____

Client First Name: _____M.I. _____Client Last Name: _____ DOB: _____

I prefer to be called: _____ Gender: _____ Pronouns: _____Age: _____

Street Address: _____ City: _____

State: _____Zip: _____ Cell: _____ Alt. Phone (home, work): _____

Can I leave a voice message? _____ Text messaging? ___yes ___no ***indicate preferred contact method***

Email Address: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

If under 18, Parent/Guardian(s) Name: _____ Phone: _____

Parent/Guardian Email: _____Alt. Phone: _____

Insurance Provider: _____ ID#: _____

Note: If you are not the primary person listed on the insurance policy provide the full name & DOB of the subscriber

Subscriber Full Name: _____Relationship: _____ DOB: _____

Reason(s) for Seeking Therapy: _____

_____

_____

How long has this been a problem for you? _____

Goals You Wish to Achieve: _____

_____

_____

Have you been in Therapy before? If yes, with whom, when, for what? _____

_____

Describe previous experiences in Therapy (positives, negatives, likes, dislikes): _____

_____

Termination Reason: _____ May I contact your previous therapist(s)? ___yes ___no

MEDICAL HISTORY **Overall physical health:** ___ excellent ___ good ___ fair ___ poor

Primary Care Physician Name: _____ **Approx. Date of Last Visit:** _____

Current Medications & Diagnosis (include name, dosage and amount of time on medication): _____

Reason for Current Medication: _____

Past Medications & Diagnosis (include name, dosage, when discontinued and why): _____

_____

Have you ever been hospitalized for a physical illness? _____ **Describe:** _____

Have you ever been hospitalized for a mental illness? _____ **Describe:** _____

Any medical conditions, illnesses or surgeries? _____

Recurrent or chronic conditions? _____

Psychiatrist? ___yes ___no **Name:** _____ **How often:** _____

Exercise? ___yes ___no **Days per Day/Week:** _____ **Describe:** _____

Smoke/vape? ___yes ___no **Amount per Day/Week:** _____**Since when:** _____

Alcohol? ___yes ___no **Amount per Day/Week:** _____ **Type:** ___beer ___ wine ___ liquor ___ other

Illegal substances? ___yes ___no **Type:** _____**Amount:** _____ **Frequency:** _____

Criminal History: ___yes ___no **Describe arrest & convictions:** _____

Do you have any weapons (guns, knives, explosives etc.)? _____

SCHOOL/WORK HISTORY

Current student: ___yes ___no **Grade:** _____ **Special Ed:** ___yes ___no **School Name:** _____

If you completed school, diploma(s)/degree(s)? _____

How are you/were your grades in school? ___excellent___good ___ fair __ poor **Ever held back?** ___yes ___no

Employed: ___yes ___no **Occupation:** _____ **How long?** _____

School/work aspirations? _____ **Dream Job:** _____

Hobbies/Interests: _____

Describe your current financial situation: ___Great ___Good ___Getting By ___Problematic ___Very Problematic

FAMILY INFORMATION **Who do you currently live with?** _____

Mother: _____ **Age:** _____ **Describe Relationship:** _____

Occupation: _____ Currently Employed? _____

Father: _____ **Age:** _____ **Describe Relationship:** _____

Occupation: _____ Currently Employed? _____

If parent(s) deceased, what year? _____Your age at the time: _____Cause of death: _____

Parents divorced? ___yes ___no **If yes, what year:** _____**Your age at the time:** _____ **Impact:** _____

Step-parents? _____ **If yes, describe when and your relationship with them**_____

If raised by someone other than your birth parents, explain: _____

Siblings Names & Ages: _____

Step or Half Siblings? _____

Describe any other significant family members: _____

Pets: _____ **List significant losses:** _____

Friends: _____

Are you married? ___yes ___no **Dating?** ___yes ___no **Single?** ___yes ___no **Polyamorous?** ___yes ___no **How long?** _____

Spouse/Partner's Name: _____**Occupation:** _____**Describe Relationship:** _____

Have Child(ren)? _____ **Age(s):** _____

PERSONAL AND FAMILY HISTORY

Addiction: ___yes ___no **Substance Abuse:** ___yes ___no **Domestic Violence:** ___yes ___no **Trauma:** ___yes ___no

Physical Abuse: ___yes ___no **Emotional Abuse:** ___yes ___no **Sexual Abuse:** ___yes __no **Mental illness:** ___yes ___no

If you answered yes to any of the above, describe: _____

_____

Are you religious/spiritual? ___yes ___no **Denomination:** _____

If I could be granted three wishes, they would be: (1) _____ (2) _____ (3) _____

BEHAVIORS – circle any of the following behaviors that apply to you

Cry often	Over eat	Smoke/Vape	Suicidal	Job loss	Loss of control	Temper tantrum
Sleep disturbance	Disordered eating	Abuse substance(s)	High risk behaviors	Odd behaviors	Phobic avoidance	Aggressive behavior
Insomnia	Vomiting	Drinking	Nervous tics	Lack of motivation	Procrastination	Impulsive reactions
Work too hard	Inattentive	Withdrawal	Instability	Paranoid	Argumentative	Compulsions

Are there any specific behaviors, actions, habits that you would like to change?

FEELINGS – circle any of the following feelings that apply to you <u>often</u>

Angry	Guilty	Unhappy	Annoyed	Happy	Bored	Sad
Conflicted	Restless	Depressed	Regretful	Lonely	Anxious	Hopeless
Content	Fearful	Hopeful	Excited	Panicky	Helpless	Optimistic
Energetic	Relaxed	Tense	Envious	Jealous	Inattentive	Others: _____

Most days I feel _____. I would like to feel _____more often.

Suicidal thoughts? ___yes ___no Current? ___yes ___no When? _____ Suicide attempts? _____

Self-harming behaviors? ___yes ___no Current? ___yes ___no When? _____ Explain: _____

Homicidal thoughts? ___yes ___no When? _____Towards whom? _____ Current? ___yes ___no

Auditory or visual hallucinations? ___yes ___no Current? ___yes ___no When? _____ Explain: _____

Certified therapy dog(s) to join us? ___Yes ___No How did you hear about my services/who referred you? _____

Share anything else you think would be helpful for me, as your therapist, to know _____

By signing below, clients certify that all of the information provided is accurate, to the best of their knowledge. Clients and, if applicable, parents/guardians understand that it is the client's responsibility to provide only accurate and updated information to the therapist/treatment team at all times and that information contained herein and in sessions may be used for diagnostic and treatment planning purposes and may be shared with insurance companies, billing consultants or contractors and consultants or employees for medical record, supervision, billing, reimbursement and treatment planning purposes.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

(only if under 18)