LOTUS COUNSELING CENTER, LLC

Amber Trepagnier, LPC, NCC
1 Galleria Blvd, Ste 1900 #1903
Metairie, LA 70001
504-444-1149

ADULT INTAKE PACKET

Please provide the following information and answer the questions below. Please note, information you provide here is protected as confidential information. Please fill out the form and bring to your first session.

Name: _____
(Last) (First) (Middle Initial)

Date of Birth: _____ /_____ /_____ **Age:** _____ **Gender:** _____

Marital Status: ☐ Single ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Please list any children & their age or anyone living with you & their age:

_____

_____

Address: _____

City: _____ **State:**_____ **Zip:** _____

Cell Phone: _____ **May we leave a message?** ☐ Yes ☐ No

Email: _____ **May we email you?** ☐ Yes ☐ No

Referred by (if any): _____

Emergency Contacts:

_____
(Name) (Number) (Relation)

_____
(Name) (Number) (Relation)

_____
(Name) (Number) (Relation)

Have you previously received any type of counseling or mental health services? ☐ Yes ☐ No

Previous provider: _____
(Name) (Office Number)

Are you currently taking any medication? ☐Yes ☐No Prescriber: _____

Name	Length of time	Condition treated
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

Last Physical Exam: _____ PCP: _____

1. **How would you rate your general health?**
☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Very Good

Please list any specific health problems you are currently experiencing: _____

_____

_____

2. How would you rate your sleeping habits?
☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Very Good

Please list any specific sleep problems you are currently experiencing: _____

_____

_____

3. How many time a week do you generally exercise? _____

4. Please list any difficulties you experience with your appetite or eating patterns: _____

_____

5. Are you currently experiencing overwhelming sadness, grief, or depression? ☐Yes ☐No
If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias? ☐Yes ☐No

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing chronic pain? ☐Yes ☐No

If yes, please describe. _____

8. Do you drink more than once a week? ☐Yes ☐No

9. Do you engage in recreational drug use? ☐Yes ☐No If yes, how often? _____

10. Are you currently in a romantic relationship? ☐Yes ☐No

If yes, how long? _____ On a scale of 1-10, how would you rate your relationship? _____

11. Are you currently having suicidal thoughts? ☐Yes ☐No If yes, for how long? _____

Is there a Means? ☐Yes ☐No _____ Is there a Plan? ☐Yes ☐No _____

12. Do you currently have thoughts of harming someone? ☐Yes ☐No If yes, for how long? _____

Is there a Means? ☐Yes ☐No _____ Is there a Plan? ☐Yes ☐No _____

13. Please list any significant life changes or stressful events have you experienced recently. _____

_____

_____

FAMILY MENTAL HEALTH HISTORY

In this section below identify if you or family member has a history of any of the following. If yes, please indicate if it is self and/or family member's relationship to you in the space provided (father, mother, uncle, etc.).

Alcohol/Substance Abuse ☐Yes ☐No _____

Anxiety ☐Yes ☐No _____

Depression ☐Yes ☐No _____

Eating Disorders ☐Yes ☐No _____

Obesity ☐Yes ☐No _____

Obsessive Compulsive Disorder ☐Yes ☐No _____

Suicide Attempts ☐Yes ☐No _____

ADDITIONAL INFORMATION

1. Are you currently employed? ☐Yes ☐No If yes, occupation: _____

Do you enjoy your work? Is there anything stressful about your current work? _____

_____

_____

2. Highest level of education completed: _____

3. Have you ever been arrested? ☐Yes ☐No If yes, explain why: _____

_____

4. Do you consider yourself to be religious or spiritual? ☐Yes ☐No Describe your faith or belief: _____

_____

5. What are your strengths? _____

_____

6. What are your weaknesses? _____

_____

7. What would you like to accomplish out of your time in therapy? _____

_____

_____