LOTUS
COUNSELING CENTER

NEW PATIENT 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 this form and bring it to your first session.

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

Name of parent/guardian (if the patient is under 18 years old):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ **Age:** _____ **Gender:** ☐ Male ☐ Female ☐ Other: _____

Marital Status:

☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Please list any children & their age:

_____

_____

Address: _____

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

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

Home/Other Phone: (_____)_____ May we leave a message? ☐Yes ☐No

E-mail: _____ May we email you? ☐Yes ☐No

Referred by (if any): _____

1428 Brickell Ave, Suite 403, Miami, FL 33131
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Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? Please check one: ☐ No ☐ Yes

Previous therapist/practitioner:

Name: _____ **Office Number:** _____

Are you currently taking any prescription medication? ☐ No ☐ Yes

If yes, please list:

_____

_____

Have you ever been prescribed psychiatric medication? ☐ No ☐ Yes

If yes, please list and provide dates:

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (Please check one.)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific health problems you are currently experiencing:

_____

_____

_____

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2. How would you rate your current sleeping habits? (please circle)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific sleep problems you are currently experiencing:

_____

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in:

_____

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

_____

5. Are you currently experiencing overwhelming sadness, grief or depression? ☐ No ☐ Yes

If yes, for approximately how long? _____

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

If yes, when did you begin experiencing this?

_____

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

If yes, please describe:

_____

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

9. How often do you engage recreational drug use?

☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

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

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

11. Are you currently experiencing concerns with your sexuality or sexual health? ☐ No ☐ Yes

If yes, please describe: _____

_____

12. What significant life changes or stressful events have you experienced recently:

_____

_____

FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Please Circle	**List Family Member**
Alcohol/Substance Abuse	yes / no _____
Anxiety	yes / no _____
Depression	yes / no _____

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Domestic Violence yes / no _____

Eating Disorders yes / no _____

Obesity yes / no _____

Obsessive Compulsive Behavior yes / no _____

Schizophrenia yes / no _____

Suicide Attempts yes / no _____

ADDITIONAL INFORMATION

1. Are you currently employed? ☐ No ☐ 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? ☐ No ☐ Yes

If yes, please explain why: _____

4. Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes

If yes, describe your faith or belief:

_____

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5. What do you consider to be some of your strengths?

_____

_____

_____

_____

_____

6. What do you consider to be some of your weakness?

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

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