Rachel Pearl VanEtten MA, LPC

Adult Intake

Please take your time in providing the following information. All information provided is confidential. We will go over the intake form during our first session. Thank you!

Referred by:

Have you previously received any type of mental health services? Yes No
If yes, which of the following:
Psychotherapy
Medication
Outpatient Hospitalizations Inpatient Hospitalization. I*f yes, please provide:*
Name of provider or facility, location, dates of treatment, reason for treatment:

____

____

Briefly, what brings you in today? In your own words, what is your goal for therapy?

____

____

When did your problem first start?

Within the last: 30 days 6--12 months 2 years

During adolescence During childhood

What areas of your life have been affected because of this problem?

Are you currently experiencing overwhelming sadness, grief or depression?
Yes No
If yes, for approximately how long: ______________________________________

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

If yes, when did you begin experiencing this? ____

Please describe any major losses or traumas you have experienced:

____

____

What significant life changes or stressful events have you experienced recently?

____

____

Family History:
Where were you born? ____

Where did you grow up? ____
City Suburbs Country

Please list your parents and siblings.
Name Age Relationship

____

____

____

Where do they live now? If deceased, age and cause of death:______________________________

Who did you live with while growing up?

____

Mother's occupation? ____

Father's occupation? ____

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.).

Condition:
Alcohol/Substance Abuse Anxiety
Depression
Domestic Violence
Sexual Abuse
Eating Disorders
Obesity
Obsessive Compulsive Disorder
Schizophrenia
Suicide Attempts
Other diagnosed mental health condition?

Marital Status:
Domestic Partner   Married   Separated   Divorced -- For how long?

Widowed: Please provide your partners name and year deceased:

If married, how long have you been married for and what is your partners name:
____

On a scale of 1-10 (best), how would you rate your relationship? Please explain.
____

Are you currently in a romantic relationship? Yes, how long? ______No______

On a scale of 1-10 (best), how would you rate your relationship? Please describe.
____

____

Please list any children, their names, and ages:

Physical Health:
Please list any medications.

Medication/Supplement	Dosage	Condition	Date Began/Stopped

Prescribing provider and contact information:
Primary Care Provider Name: ______________________________ROI completed?___________
Address, Phone, Email, or Fax:

____

How would you rate your current physical health?
Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits?
Poor Unsatisfactory Satisfactory Good Very Good

If you are having problems, in which phase of sleep are you experiencing issues?
Falling asleep Staying asleep Awakening early Sleep apnea

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

____

How many times per week do you generally exercise? ___________________________________

What types of exercise do you participate in:
____

Please describe your eating habits? 3 meals/day? Any food related challenges?

____

Are you currently experiencing any chronic pain? No Yes
If yes, please describe:____

Please describe previous and current use of alcohol, cigarettes, and/or recreational drugs:

____

____

Additional Information:
What do you enjoy about your work (full-time at home included)?

____

What do you find particularly stressful about your current or previous work?

____

What do you enjoy doing in your free time? What do you do to relax? Self-Care?

____

____

____

Do you consider yourself to be spiritual or religious? ________________________________

If yes, please describe your faith or belief: _____________________________________

What are your strengths?

____

____

What areas would you like to grow? ____________________

Anything else you'd like me to know about you?

____

____

Care Plan/Support Network:

List 3 adults you will contact when needing emotional and/or physical support:

____

____

____

Client has received emergency contacts information and numbers for, 911for any emergencies, Colorado 24/7 Crisis Line, Suicide Hotline, and Parenting Hotline Information.

____

Client Signature **Date**