

# new client intake

Rachel Lund, MA, LMHC

206.414.8918

rachel@rachellundcounseling.com

7220 Woodlawn Ave NE #306

Seattle, WA 98115

## Contact Information:

name: \_\_\_\_\_ age: \_\_\_\_\_ sex: M F

address: \_\_\_\_\_

e-mail \_\_\_\_\_

date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

phone:	home: _____	OK to call you here?	Yes	No
	work: _____	OK to call you here?	Yes	No
	mobile: _____	OK to call you here?	Yes	No

emergency contact name: \_\_\_\_\_

emergency contact phone #: \_\_\_\_\_

occupation \_\_\_\_\_ education level \_\_\_\_\_

ethnicity \_\_\_\_\_ religion \_\_\_\_\_ practicing? Yes No

## Statement of Need

Please provide a brief description of your reasons for seeking counseling at this time:

How have these concerns evolved over time?

What are your goals for our counseling work?

## Symptom Inventory & Treatment History

Please rate the severity of the following symptoms over the last month according to the following rating scale:

**0: no difficulty**

**1: mild**

**2: moderate**

**3: severe**

- |  |  |
|--|--|
| _____ Decreased appetite   | _____ Nightmares                         |
| _____ Increased appetite/eating more   | _____ Hyper vigilance                    |
| _____ Bingeing and/or purging  | _____ Obsessive thoughts                 |
| _____ Weight change? +/- _____ lbs.  | _____ Compulsions                        |
| _____ Depressed mood   | _____ Spending sprees                    |
| _____ Decreased energy/fatigue   | _____ Racing thoughts                    |
| _____ Sleep changes: trouble falling asleep;<br>trouble staying asleep; trouble<br>waking up | _____ Rapid heart beat                   |
| _____ Avg. # hours sleep _____   | _____ Trouble breathing                  |
| _____ Decreased sexual desire  | _____ Sweating                           |
| _____ Difficulty with sexual functioning   | _____ Phobia                             |
| _____ Loss of interest in activities   | _____ Police/Probation involvement       |
| _____ Crying   | _____ Stealing                           |
| _____ Feelings of hopelessness   | _____ Lying                              |
| _____ Feelings of helplessness   | _____ Truancy                            |
| _____ Decreased attention span   | _____ Violent behavior towards<br>others |
| _____ Inattentive/Distractible   | _____ Destruction of property            |
| _____ Memory problems: Long-term;<br>short-term  | _____ Harming animals                    |
| _____ Self-injurious behavior  | _____ Fire setting                       |
| _____ Thoughts of suicide  | _____ Opposition                         |
| _____ Thoughts of harming others   | _____ Anger outbursts                    |
| _____ Flashbacks of traumatic event  | _____ Irritability                       |
| _____ Impulsivity  | _____ Hyperactivity                      |
|  | _____ Anxiety/Nervousness                |
|  | _____ Worry/Fear                         |

How many alcoholic beverages do you consume per week? \_\_\_\_\_

List street drugs used in last 2 months (type/frequency/amount): \_\_\_\_\_

\_\_\_\_\_

Family history of substance abuse problems? \_\_\_\_\_

\_\_\_\_\_

Previous psychological or psychiatric treatment? (List dates & provider names): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any psychiatric hospitalizations? \_\_\_\_\_

\_\_\_\_\_

Medical history: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current medications & dosages: \_\_\_\_\_

\_\_\_\_\_

Name of prescribing physician: \_\_\_\_\_

Current stressors: \_\_\_\_\_

\_\_\_\_\_

Have you ever attempted or considered suicide? Y / N (If yes, please provide some detail):

\_\_\_\_\_

\_\_\_\_\_

Any other information you would like your therapist to know? \_\_\_\_\_

\_\_\_\_\_

Rachel Lund, MA, LMHC

206.414.8918

rachel@rachellundcounseling.com

7220 Woodlawn Ave N #306