Intake Interview

Please complete the following form. If you have any questions, call (805) 714-6908. Mail completed form to:

Lotus Garden
1136 Pino Solo Drive
Santa Maria, CA 93455

Name:

Date of Birth:

Age:

Female _____ Male_____

Mailing Address (street, city, state, zip code)

Phone:

Do you know sources of support and help available to you locally after you complete this program? (Counselors, support groups, supervision, etc) Yes_____ No_____

If yes, list source and how often you use it (as part of your aftercare process, you may be asked to make some choices using these resources).

EMERGENCY CONTACT INFORMATION:

Please give a name and phone number(s) or a person we could reach in case of an emergency while you are attending our workshop:

Name:	
Relationship:	
Home Phone:	
Work Phone:	
Cell Phone:	

CHILDHOOD/ADOLESCENCE:

What were *CHILDHOOD ages 1-13* were like: Happy____Unhappy____Other_____
Describe:

Any problems in school? Yes ____ No ____
If yes, please describe:

Get along with classmates? Yes ____ No ____
If yes, please describe:

Have many friends? _____

Free or leisure time was mostly spent:

What were *ADOLESCENT ages 13-18* were like: Happy___Unhappy___Other_____
Describe:

Any problems in school?
Yes ____ No ____ If yes, please describe:

Get along with classmates?
Yes ____ No ____ If yes, please describe:

Have many friends? _____

Free or leisure time was mostly spent:

Describe any particular event or person that had a significant effect on your life:

MARITAL AND FAMILY CIRCUMSTANCES:

Current Relationship Status:

Single___ Married___Divorced___Separated___Widowed___

How many committed relationships have you been in? ___

First_____ Your Age_____

Second____ Your Age_____

Third_____ Your Age_____

If applicable, reason for divorce (include divorce dates)

First:

Second:

Third:

Quality of relationship with your present partner:

ACTIVITIES AND SOCIAL INTERESTS:

I have _____ few ____ many friends. The quality of my relationships with friends is:

I enjoy group settings:
Yes ____ No ____. If no, please explain:

Please list the clubs or organizations that you belong to:

Please list games or sports you are most interested in

Please list creative interests:

How much are you involved in any of the activities listed above? Explain:

TREATMENT HISTORY:

Do you currently have one of these chemical dependencies? How often do you use the following?

Type:	Yes	No	How often to you use these per week?
Nicotine			
Alcohol			
Over-the-Counter Drugs			
Other Drugs			

Have you ever been treated for chemical dependency? Yes____ No ____
If yes, please provide the following:

Where:	When:	Length of Treatment:	Reason (eg, alcohol, drugs, etc):

If more than three, please use back of this page.

Have you ever had psychiatric, marriage, codependency, eating disorder, or any other type of counseling? Yes __ No __

Counselor Type:	When:	Length of Treatment:	For:

If more than three, please use back of this page.

How much concern do you have about yourself regarding the following:

What:	**Extreme**	**Periodic**	**Not At All**
Overeating			
Under Eating or Dieting			
Vomiting			
Binge Eating			
What:	**Extreme**	**Periodic**	**Not At All**
Excessive Exercise			
Weight or Body			
Your Alcohol Use			
Your Drug Use			
Sexual Thoughts/ Behaviors			
Caretaking Behaviors			
What:	**Extreme**	**Periodic**	**Not At All**
Gambling			
Financial Spending			
Nicotine Use			
Working/Busyness			
Perfectionism			
Illness/Physical Health			
Professional Burnout			

Please write any additional comments about your answers.

FEELINGS, EMOTIONS, AND EVALUATIONS:

On the following scale, please rate with an "X" your present performance in the areas indicated on the left.

What:	Very Poor (Many Problems)	Average	Very Good (Few, If Any, Problems)
Physical			
Emotional			
Spiritual			
Job			
Family			
Financial			
Social			
Legal			
Self-worth			

How do you picture yourself? (Describe yourself in your own words.)

What are your strengths?

What are your weaknesses?

Do you have fears or anxieties about anything? Yes_____ No _____.
If yes, please explain:

What losses have you experienced?

Have you ever had:

What:	Yes	No	Drug/Alcohol Related:	When:
Suicide Thoughts				
Suicide Plans				
Suicide Attempts				

Please describe any yes answers:

Do you currently have any physical limitations or medical conditions? Yes ____ No ____

If yes, please explain:

Do you have any special dietary needs? Yes ____ No ____

If yes, please explain:

Please list any and all medications (prescription or non-prescription) including dosages and reason taken (continue on the back if you need more space):

Medication:	Prescribed for:	Dosages:

What would you like to change in your life?

How might this Lotus Garden retreat or workshop help you?