Positive Change Counseling Services

A Professional Corporation of Marriage and Family Therapists

406 Main Street

Vacaville, CA 95688

(707) 446-8600

Adult Intake Paperwork

Today's Date_________________

Referred By__________________

Please take time to fill out this form. This will help in providing appropriate therapeutic care for you.

Name____Date of Birth___________________

Address___________________________________ City_______________________ Zip_____________

Phone________________________ Email____

Level of Education________________________ Current Occupation_____________________________

Emergency Contact____________________________________ Phone___________________________

Relationship to Client____________________________

Address___________________________________ City______________________

Current Living Situation

Please circle which of the following best describes your living situation.

Rent apartment	Shelter
Rent house	Homeless
Own house	Group home
Foster care	Residential treatment

Support System

List the household members living in your home at this time.

Name_____________________________________ Age_______ Relationship to you___________________

Name_____________________________________ Age_______ Relationship to you___________________

Name_____________________________________ Age_______ Relationship to you___________________

Name_____________________________________ Age_______ Relationship to you___________________

Name_____________________________________ Age_______ Relationship to you___________________

Name_____________________________________ Age_______ Relationship to you___________________

Name_____________________________________ Age_______ Relationship to you___________________

List important friends, family members or relatives living outside of your home.

Name_____________________________________ Age_______ Relationship to you___________________

Name_____________________________________ Age_______ Relationship to you___________________

Name_____________________________________ Age_______ Relationship to you___________________

Name_____________________________________ Age_______ Relationship to you___________________

Name_____________________________________ Age_______ Relationship to you___________________

Name_____________________________________ Age_______ Relationship to you___________________

Name_____________________________________ Age_______ Relationship to you___________________

Areas of Concern

What issues/concerns cause you to seek treatment? Please describe.

____

____

____

What would you like to achieve in therapy?

____

____

____

Do you have any concerns or fears about therapy?

____
____

Psychological History

Name of previous therapist_____________________________ Phone________________________

Dates of treatment_______________________ Focus of treatment__________________________

What was helpful/not helpful about treatment?____

____

Have you had psychological testing?_________ If yes, by whom?_____________________________

Have you ever had suicidal or homicidal?____________

• Thoughts?__________

• Attempts?__________

Have you been hospitalized for mental or emotional problems?_______

If so,

• When?____

• How long?____

• What was the reason?_________________________________

Hospital Name_______________________________________

Current Medications

1. Name of medication___________________________________ Dose_________________ Start Date__________ Prescribed by______________________Phone__________________ 2. Name of medication___________________________________ Dose_________________ Start Date__________ Prescribed by______________________Phone__________________ 3. Name of medication___________________________________ Dose_________________ Start Date__________ Prescribed by______________________Phone__________________ 4. Name of medication___________________________________ Dose_________________ Start Date__________ Prescribed by______________________Phone__________________

Medical History

Have you ever been diagnosed with a serious illness?

Please describe____

Date of last physical exam______________ Physician_____________________________ Phone__________

Are you experiencing any medical/physical symptoms you attribute to emotional, or stress-related condition? Please describe____

Have you ever been in a 12-step program? Yes______ No______

How much alcohol do you drink per week? ____

How much marijuana do you use per week?____

Do you currently use illegal drugs?_____________________

If so,

- What type?____
- How often___________________________________

Have you ever used alcohol or drugs in the past?________________

If so,

- What type___________________________________
- How often?____

Family of Origin History

Mother's name, age, living/deceased, description of your relationship with Mother.

____
____
____

Father's name, age, living/deceased, description of your relationship with Father.

____
____
____

Please describe your childhood experience.

____
____
____

Were you ever subjected to abuse? Please describe verbal, bullying, physical, and/or emotional abuse.

____
____
____

Have you ever been a victim of a violent crime? Please describe.

____
____
____

Other Information

Spiritual identity/Orientation____
Interests/Hobbies____

Legal Issues

- Lawsuits? __Yes ___No
- Parole/Probation Officer? ___Yes ___No
- Restraining Orders? ___Yes ___No
- Divorce? ___Yes ___No
- Custody Dispute? ___Yes ___No

Areas of Concern

Please check any areas you or your family may be concerned about. Check all that apply.

__Depression	__Strange behaviors	__Lack of friends
__Crying a lot	__Paranoia	__Avoid others
__Sexual abuse	__Destroy things	__Lack of attention
__Obsessive thoughts	__Learning difficulties	__Stealing
__Anxiety	__Promiscuity	__Panic attacks
__Physical abuse	__Hopelessness	__Self injurious behaviors
__Obsessive thoughts	__Suicidal thoughts/plans	__Vandalism
__Hot temper	__Odd beliefs	__Fire setting

__Gambling __Substance use __Violence

__Nightmares __Hyperactivity __Physical problems

__Worry excessively __Perfectionist __Weight loss

Strengths

Please check any areas you or your family consider your strengths. Check all that apply.

__Employed	__Easy going	__Athletic
__Independent	__Regularly copes well	__Structures time well
__Intelligent	__Caring	__Loyal
__Responsible	__Honest	__Positive outlook
__Spiritual	__Helpful	__Artistic
__Playful	__Good looking	__A leader

Thank you for taking the time to fill out this intake form.

____

Printed Name Signature Date