Positive Change Counseling Services
A Professional Corporation of Marriage and Family Therapists
850 Merchant Street, Suite A
Vacaville, CA 95688
(707) 446-8600

Adult Intake Paperwork

Today's Date_____

Referred By_____

Please take time to fill out this form. This will aid greatly 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. Please check.

- 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
__Weight loss	__Suicidal thoughts/plans	__Vandalism
__Hot temper	__Odd beliefs	__Fire setting
__Gambling	__Substance use	__Violence
__Nightmares	__Hyperactivity	__Physical problems
__Worry excessively	__Perfectionist	

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

Appointment Reminders:

I consent to receive appointment reminders from Positive Change Counseling Services in the following formats (check any/all that apply):

- ☐ Email
- ☐ Text Message
- ☐ Phone Call

_____

Printed Name Signature Date