Positive Change Counseling Services

A Professional Corporation of Marriage and Family Therapists

2050 Peabody Road, Suite 300

Vacaville, CA 95687

(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
__Crying a lot
__Sexual abuse
__Obsessive thoughts
__Anxiety
__Physical abuse
__Weight loss
__Hot temper
__Gambling
__Nightmares
__Worry excessively

__Strange behaviors
__Paranoia
__Destroy things
__Learning difficulties
__Promiscuity
__Hopelessness
__Suicidal thoughts/plans
__Odd beliefs
__Substance use
__Hyperactivity
__Perfectionist

__Lack of friends
__Avoid others
__Lack of attention
__Stealing
__Panic attacks
__Self injurious behaviors
__Vandalism
__Fire setting
__Violence
__Physical problems

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