Positive Change Counseling Services

A Professional Corporation of Marriage and Family Therapists

406 Main Street
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(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	Foster care	Group home
Rent house	Shelter	Residential treatment
Own house	Homeless	

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_____

- Lawsuits? __Yes ___No.
- Restraining Orders? ___Yes ___No
- Divorce? ___Yes ___No
- Parole/Probation Officer? ___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
__Obsessive thoughts
__Hot temper
__Strange behaviors
__Paranoia
__Destroy things
__Learning difficulties
__Promiscuity
__Hopelessness
__Suicidal thoughts/plans
__Odd beliefs
__Lack of friends
__Avoid others
__Lack of attention
__Stealing
__Panic attacks
__Self injurious behaviors
__Vandalism

__Fire setting

__Legal Issues

__Gambling

__Nightmares

__Worry excessively

__Substance use

__Hyperactivity

__Perfectionist

__Violence

__Physical problems

__Weight loss

Strengths

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

__Employed

__Independent

__Intelligent

__Responsible

__Spiritual

__Playful

__Easy going

__Regularly copes well

__Caring

__Honest

__Helpful

__Good looking

__Athletic

__Structures time well

__Loyal

__Positive outlook

__Artistic

__A leader

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

_____

Printed Name Signature Date