

Positive Change Counseling Services

A Professional Corporation of Marriage and Family Therapists
2050 Peabody Road
Suite 300
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.

- | | | |
|---|--|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Strange behaviors | <input type="checkbox"/> Lack of friends |
| <input type="checkbox"/> Crying a lot | <input type="checkbox"/> Paranoia | <input type="checkbox"/> Avoid others |
| <input type="checkbox"/> Sexual abuse | <input type="checkbox"/> Destroy things | <input type="checkbox"/> Lack of attention |
| <input type="checkbox"/> Obsessive thoughts | <input type="checkbox"/> Learning difficulties | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Promiscuity | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Self injurious behaviors |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Suicidal thoughts/plans | <input type="checkbox"/> Vandalism |
| <input type="checkbox"/> Hot temper | <input type="checkbox"/> Odd beliefs | <input type="checkbox"/> Fire setting |
| <input type="checkbox"/> Gambling | <input type="checkbox"/> Substance use | <input type="checkbox"/> Violence |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Physical problems |
| <input type="checkbox"/> Worry excessively | <input type="checkbox"/> Perfectionist | |

Strengths

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

- | | | |
|--------------------------------------|---|---|
| <input type="checkbox"/> Employed | <input type="checkbox"/> Easy going | <input type="checkbox"/> Athletic |
| <input type="checkbox"/> Independent | <input type="checkbox"/> Regularly copes well | <input type="checkbox"/> Structures time well |
| <input type="checkbox"/> Intelligent | <input type="checkbox"/> Caring | <input type="checkbox"/> Loyal |
| <input type="checkbox"/> Responsible | <input type="checkbox"/> Honest | <input type="checkbox"/> Positive outlook |
| <input type="checkbox"/> Spiritual | <input type="checkbox"/> Helpful | <input type="checkbox"/> Artistic |
| <input type="checkbox"/> Playful | <input type="checkbox"/> Good looking | <input type="checkbox"/> 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