Positive Change
for Teens and Families

Adult Client Intake Form

Please provide the following information and answer the questions below.
Please note: information you provide here is **protected and confidential**

Please print and fill out this form and bring it to your first session.

Name:_____
(Last) (First) (MI)
Nickname/Name you would prefer to be called: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: _____

Home Phone: _____ Cell Phone: _____

Email:_____
**Please note: email correspondence is not considered to be a confidential method of communication*

How would you prefer to be contacted? _____
**Please place a star next to each phone number where we can leave a message*

Home Address:
_____

Emergency Contact:
_____
(Last) (First)

Relationship to you: _____ Phone number: _____

How were you referred to our practice? _____

Primary Care Doctor/NP:
_____
(Name) (Phone Number)
Address of PCP/PNP:
_____

Have you ever received any type of mental health services (inpatient, outpatient, psychiatric, psychotherapy, school counseling, evaluation etc…)?

☐ Yes ☐ No

If Yes, Previous therapist/ provider: _____

Can we contact this provider? ☐ Yes ☐ No _____
(Phone Number)

Are you currently taking any medications? ☐ Yes ☐ No

Medications	Dosage	Prescribed for?

General Health and Mental Health Information:

1. How would you rate your physical health? (Please circle)

   Poor Unsatisfactory Satisfactory Good Very Good

2. How would you rate your current mental health? (Please Circle)

   Poor Unsatisfactory Satisfactory Good Very Good

3. Please rate your current appetite

   Poor Unsatisfactory Satisfactory Good Very Good

4. Please rate your current mood

   Poor Unsatisfactory Satisfactory Good Very Good

5. How would you describe your mood? _____

6. Are you currently experiencing any feeling of overwhelming sadness, grief or numbness?

☐ Yes ☐ No

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any anxiety/ panic attacks or any fears? ☐ Yes ☐ No

If yes, when did you begin experiencing this? _____

8. How often do you drink alcohol or engage in recreational drug use?
☐ Never ☐ Infrequently ☐ Daily ☐ Weekly ☐ Monthly

9. How many hours of sleep do you get per night? _____

10. How many times per week do you exercise? _____ For how long? _____

11. Have you noticed any recent changes in appetite? ? ☐ Yes ☐ No

12. Are you currently in a romantic relationship? ☐ Yes ☐ No
If yes, do you feel safe in this relationship? ☐ Yes ☐ No

On a scale of 1 to 10, how would you rate your relationship? _____

13. Are you currently in school and/or employed? ☐ Yes ☐ No

If yes, where are you in school and/or employed?

_____

14. Do you consider yourself to be spiritual/ religious? ☐ Yes ☐ No

If yes, describe your spiritual faith or belief:

_____
_____
_____
_____

15. What significant life changes or stressful events have you experienced recently?

_____
_____
_____
_____
_____
_____
_____

Family Mental Health History:

In the section below, please note if there is a family history of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, sister etc…)

Condition	**Please Circle**	**List Family Member(s)**
Alcohol/Substance Abuse	yes/ no	_____
Autism	yes/no	_____
Anxiety	yes/ no	_____
Depression	yes/ no	_____
Domestic Violence	yes/ no	_____
Eating Disorders	yes/ no	_____
Learning Disabilities	yes/ no	_____
Obesity	yes/ no	_____
OCD/ Phobias	yes/ no	_____
Physical/ Sexual Abuse	yes/ no	_____
Schizophrenia	yes/ no	_____
Suicide Attempts	yes/ no	_____
Suicide Completion	yes/ no	_____
Other: _____	Family Member: _____	

Family Medical History:

Condition	**Please Circle**	**List Family Member(s)**
Acne	yes/no	_____
Alzheimer's	yes/no	_____
Arthritis	yes/no	_____
Asthma	yes/no	_____
Autoimmune Disease	yes/no	_____
Brain Injury	yes/no	_____

Cancer	yes/no _____
Diabetes Mellitus	yes/no _____
Down Syndrome	yes/no _____
Epilepsy	yes/no _____
Gastrointestinal Disease	yes/no _____
High Blood Pressure	yes/no _____
Heart Disease	yes/no _____
Infectious Diseases	yes/no _____
Migraines	yes/no _____
Obesity	yes/no _____
Other Illness: _____	Family Member: _____

Additional Information:

What are your top three strengths?

_____
_____
_____

What are the three things you would most like to improve about yourself?

_____
_____
_____

What are the three things that cause you the most stress?
(Please list in order of most to least stressful)

1.
2.
3.

What would you like to accomplish during your time in therapy?

_____
_____
_____
_____

Thanks for taking the time to fill out this form

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