Positive Change
for Teens and Families

Teen/ Young 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?

    _____
    _____
    _____
    _____
    _____

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

1315 Walnut Street Suite 806
Philadelphia, PA 19107
(215) 545-3700 fax (215) 545-3711
www.positivechangeforfamilies.com