YOUNG ADULT CLIENT INTAKE FORM

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Please answer the following questions to the best of your abilities. These questions are to help the therapist with the therapy process. This information is held to the same standards of confidentiality as our therapy. This questionnaire will take approximately 15 minutes to complete.

Name:____
(Last) (First) (Middle Initial)

Name of parent or guardian (if under 18):______________________________________
(Last) (First) (Middle Initial)

Current address: ____

____

Cell Phone (parent): ______________________ May Therapist leave a message? Yes No

Cell Phone (client):______________________ May Therapist leave a message? Yes No

Email (parent):__________________________ May Therapist email you?* Yes No

Email (client) __________________________May Therapist email you?* Yes No

*NOTE: Emails may not be confidential

Birth date: ______/______/_____ Age:________ Gender: Male / Female / Other Identification

Are you currently in a romantic relationship? Yes No

If yes, how long have you been in this relationship?________________________________

On a scale from 1-10 (10 being great), how would you rate the quality of your relationship? __________________

Do you have siblings? Yes No How many? ________ Ages:_________________________

Is your Mother still living? Yes No Is your Father still living? Yes No

How did you find me? :____

Are you currently attending school? Yes No

If yes, what grade are you in and what school? ______________________________________

Are you happy in school? Yes No

If no, why? ____

____

Mental Health Services Information

Are you currently receiving psychological services, professional counseling, psychiatric services, or any other mental health services? Yes No

Reason for change:____

Have you had any mental health services in the past? Yes No

Are you currently taking any psychiatric prescription medication? Yes No

If yes, please list:____

Have you been prescribed psychiatric prescription medication in the past? Yes No

If yes, please list:____

General Health and Mental Health Information

How is your physical health at the present time? Poor Unsatisfactory Satisfactory Good Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, thyroid dysfunction, etc.): ____
____
____

Are you on any medication for physical/medical issues? Yes No
If yes, please list:____

Are you having any problems with your sleep habits? Yes No
If yes, circle those that apply:

Sleep too much Sleep too little Poor quality Disturbing dreams Other:_____________________

How many times per week do you exercise? ____________________ days ____________________ minutes/hours

Are there any changes or difficulties with your eating habits? Yes No
If yes, circle one:

Eating less Eating more Bingeing Restricting

Have you experienced a weight change in the last two months? Yes No

Do you consume alcohol: Daily Weekly Monthly Rarely Never

In one month, how many times do you have four or more drinks in a 24-hour period?______________________

Are you using any recreational drugs? Yes No

If yes, how often? Daily Weekly Monthly Rarely

Have you felt depressed recently? Yes No

If yes, for how long?____

Have you had any suicidal thoughts recently? Yes No

If yes, how often? Frequently Sometimes Rarely

Have you ever had suicidal thoughts in your past? Yes No

If yes, how long ago?____

How often did you have these thoughts? Frequently Sometimes Rarely

In the last year, have you had any major life changes (e.g. new job, moving, illness, relationship change, etc.)?

____

____

Quick Check

Circle the issues below that apply to you.

Extreme depressed mood Mood swings Rapid speech Extreme anxiety

Panic attacks Phobias Sleep disturbance Hallucinations

Memory lapse Alcohol/substance abuse Body complaints Eating disorder

Repetitive thoughts Anxiety Time loss Repetitive behaviors

Homicidal thoughts Suicide attempts Trouble planning Difficulty with relationships

Other:____

Occupational Information

If you are of age (16), are you currently employed? Yes No

If yes, who is your employer?____

What is your position?____

Are you happy in your current position? Yes No

Are you fulfilled in your current position? Yes No

Does your work make you stressed? Yes No

If yes, what are your work-related stressors?____

Religious/Spiritual Information

Do you practice a religion? Yes No

If yes, what is your faith? ______________________________

If no, do you consider yourself to be spiritual? Yes No

Family Mental Health History

The following is to provide information about your family history. Please mark each as yes or no.
If yes, please indicate the family member affected.

			Family Member:
Depression	Yes	No	______________
Anxiety Disorders	Yes	No	______________
Bipolar Disorder	Yes	No	______________
Panic Attacks	Yes	No	______________
Alcohol/Substance Abuse	Yes	No	______________
Eating Disorder	Yes	No	______________
Learning Disability	Yes	No	______________
Trauma History	Yes	No	______________
Domestic Violence	Yes	No	______________
Obesity	Yes	No	______________
Obsessive Compulsive Behavior	Yes	No	______________
Schizophrenia	Yes	No	______________

Other Information

List your strengths ______________________________

____

List areas you feel you need to develop ______________________________

____

What do you like most about yourself? ______________________________

____

What are some ways you cope with life obstacles and stress?______________________________

____

____

What are your goals for therapy and/or what would you like to accomplish? ______________________________
____
____
____

**********FULL PAYMENT IS DUE AT THE TIME OF EACH VISIT*************

CLIENT (please print):____

PARENT (please print):
(if client is underage (18) or parent is financially responsible)

____

RESPONSIBLE PARTY ACCEPTS FINANCIAL RESPONSIBILITY FOR EXPENSES INCURRED WITH LORI OGE MA, LPC FOR THE ABOVE NAMED CLIENT.

____ ____
Signature of Responsible Party **Date**

____
Please Print your name here