

# YOUNG ADULT CLIENT INTAKE FORM

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Licensed Professional Counselor  
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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**