YOUTH'S INTAKE FORM

PAMELA KING THERAPY

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210-885-5009

CONFIDENTIAL INFORMATION*

Date _____

How did you hear of me: _____

1. Name: _____ _____ _____
Last First Middle Birth Date Age

2. Address: _____ _____ _____ _____
Street City State Zip

3. Phone: (_____) _____ **(_____)** _____
Home Mobile

4. Ethnicity (circle one): Caucasian Hispanic African American Middle Eastern Other: _____

5. E-mail address: _____

6. Grade: _____ **School:** _____

7. Employer:_____ **How Long:** _____

8. Mother's Name: _____ **Age:** _____ **Birthdate:** _____

9. Address: _____ **City:** _____ **State:** _____

Zip: _____ **Phone: (_____)**_____

10. Father's Name: _____ **Age:**_____ **Birthdate:** _____

11. Address:_____ **City:** _____ **State:** _____

Zip: _____ **Phone: (_____)**_____

12. People Living in Your Home:

Name	M/F	Age	Relationship

13. Spiritual Faith or Participation: _____

14. Would you like your spiritual beliefs to be a part of the counseling? Yes No

15. General physical and mental health:

_____

16. Illnesses/disabilities:

_____

_____

17. Medications – indicate what condition they are treating and how long you have been taking each:

_____

_____

18. Psychiatrist/Psychologist Name _____

19. Previous counseling (Circle one): Yes No

20. If yes, give reason(s) for previous counseling/therapy:

_____

_____

_____

Therapist Name _____

Organization _____

Address _____

_____

Dates of Counseling _____

Therapist Name _____

Organization _____

Address _____

_____

Dates of Counseling _____

21. Please indicate which of the following are concerning you at this time (check all that apply):

___ Alcohol/Substance abuse by self ___Family Problems ___ Eating Disorders
___ Alcohol/Substance Abuse by others ___ Poor appetite
___ Hopelessness, Helplessness ___ Fatigue
___ Sexual Addiction ___ Guilt, Worthlessness ___ Muscle Twitching
___ Physical Abuse ___ Restlessness ___ Chest Pain
___ Emotional Abuse ___ Crying Spells ___ Shortness of Breath
___ Sexual Abuse ___ Sudden weight gain/loss ___ Excessive Sweating
___ Anxiety ___ Insomnia ___ Muscle Aches
___ Thoughts of Suicide ___Excessive Sleeping ___Panic Attacks
___ Grief ___ Decreased Concentration ___ Dizziness/Faintness
___ Illness ___ Loss of interests ___ Digestive Problems
___ Spiritual Problems ___ Racing Thoughts ___ Rapid/Pounding pulse
___ Adjustments to life changes ___ Uncontrollable thoughts
___ Uncontrollable behaviors ___ Cold Hands ___ Numbness in fingers
___ Criminal Problems ___ Anger ___ Excessive Sweating

___ Financial Problems ___ Irritability ___ Dry Mouth
___ Abortion ___ Miscarriages ___ Mood Changes
___ Anti-Social Behavior/Withdrawing ___ Fear of: _____ ___ Other: _____

22. On a scale of 1-10, please rate the overall severity of your situation with 10 being the most severe:
_____

23. Please check how often the following occur to you:
Life is hopeless. ___ Never ___ Rarely ___ Sometimes ___ Frequently
I am lonely. ___ Never ___ Rarely ___ Sometimes ___ Frequently
No one cares about me. ___ Never ___ Rarely ___ Sometimes ___ Frequently
I am a failure. ___ Never ___ Rarely ___ Sometimes ___ Frequently
Most people don't like me. ___ Never ___ Rarely ___ Sometimes ___ Frequently
I want to hurt someone. ___ Never ___ Rarely ___ Sometimes ___ Frequently
I am so stupid. ___ Never ___ Rarely ___ Sometimes ___ Frequently
I am so depressed. ___ Never ___ Rarely ___ Sometimes ___ Frequently
God is disappointed with me. ___ Never ___ Rarely ___ Sometimes ___ Frequently
I am disappointed with God. ___ Never ___ Rarely ___ Sometimes ___ Frequently
I can't be forgiven. ___ Never ___ Rarely ___ Sometimes ___ Frequently
Why am I so different? ___ Never ___ Rarely ___ Sometimes ___ Frequently
I can't do anything right. ___ Never ___ Rarely ___ Sometimes ___ Frequently
I am out of control. ___ Never ___ Rarely ___ Sometimes ___ Frequently
I am unlovable. ___ Never ___ Rarely ___ Sometimes ___ Frequently

24. Check how you generally get along with other people:
___ Affectionate ___ Aggressive ___ Avoidant ___ Fight/Argue often
___Follower ___ Friendly ___ Leader ___ Outgoing
___ Shy/Withdrawn ___ Submissive ___ Other: _____

25. State the main reason you are seeking counseling at this time: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

26. How long have you been experiencing this problem? _____

27. Is this a reoccurring problem? _____

28. How long has it been since the last occurrence? _____

_____

29. Who is your support system (family members, friends)?_____

_____

_____

30. Coping Mechanisms (what do you do when you get angry, stressed, etc.): _____

_____

_____

31. Your Goal for Counseling: _____

_____

_____

_____

_____

32: Any Additional Comments: _____

_____

_____

_____

_____

CONSENT AGREEMENT

I have read the Professional Disclosure Statement, and I have completed the Intake Form.
I desire to receive counseling from Pamela King, MA, LMFT, LPC.

_____ _____
Signature Date

_____ _____
Signature of Parent or Guardian Date

_____
Full Name of Parent or Guardian (Please Print) Relationship