Youth Intake Form

The information on this form is confidential. We will not share it with anyone outside of Shine A Light Counseling Center without your written consent, except in case of emergency or when required by law.

If you don't know the answer to a question or it doesn't apply to you, you can leave it blank. If you do not understand a question, please ask your therapist during the first session.

Basic Information
Name:
Birthdate: Age:
Medi-Cal ID#:
Phone: Email:
Home address:
How do you prefer we contact you? ☐ Call ☐ Text ☐ Email
Phone messages: Is it ok for us to identify ourselves as from Shine A Light? ☐ Y ☐ N
What race do you identify with: What gender do you identify with:

Safety Issues
Have you ever attempted suicide? ☐ Yes ☐ No
If yes, what are the dates:
Have you had suicidal ideation in the last year? ☐ Yes ☐ No
Do you currently think about suicide? ☐ Yes ☐ No

If yes, do you have a plan? ☐ Yes ☐ No

If yes, do you have the means? ☐ Yes ☐ No

Reason for Seeking Treatment

Please briefly explain the history of the issues you are seeking therapy for:

Do you want anything to be different in your life?:

Which of the following affect you? (check all that apply)

- ☐ Anxiety
- ☐ Depression
- ☐ Anger
- ☐ Grief
- ☐ Loneliness
- ☐ Relationship conflict
- ☐ Chronic pain
- ☐ Addiction
- ☐ Anorexia
- ☐ Bulimia
- ☐ Overeating
- ☐ Impulse control
- ☐ Sleep problems
- ☐ Difficulty concentrating
- ☐ Fatigue
- ☐ Panic attacks
- ☐ phobias
- ☐ PTSD
- ☐ Emotional trauma
- ☐ LGBTQ issues
- ☐ Problems with Parents
- ☐ High stress
- ☐ Poor communication
- ☐ ADHD

Which statements feel true for you? (check all that apply)

- ☐ I feel tense most of the time.
- ☐ I have a lot of physical problems that can't be explained.
- ☐ I worry most of the time.
- ☐ I do some things over and over for no good reason.
- ☐ I have nightmares and/or flashbacks that
- ☐ I can't get out of my head.
- ☐ I sometimes feel shaky or unable to relax.
- ☐ I avoid social situations because I am fearful.
- ☐ There are some things I am really afraid of.
- ☐ I am afraid to leave the house.
- ☐ I can't concentrate because I have so many thoughts running in my head.
- ☐ I no longer have any interest in the things that used to interest me.
- ☐ I sometimes hurt myself intentionally.
- ☐ I get tired for no reason.
- ☐ I am sleeping too much, or too little.
- ☐ I feel unhappy.
- ☐ I become irritable or anxious easily.
- ☐ I have spontaneous urges to cry.
- ☐ I feel really self-confident lately.
- ☐ I feel happier or more cheerful than usual.
- ☐ I notice that I need less sleep than usual.
- ☐ I can't make decisions because I have a difficult time concentrating.
- ☐ I feel sluggish and restless.
- ☐ I am gaining or losing weight without trying to.
- ☐ I talk more frequently and find it difficult to be interrupted.
- ☐ I am more active or "on the go" than usual.
- ☐ I feel hopeless about the future.

Psychiatric History

Have you ever been admitted to a psychiatric hospital? If so, please briefly explain circumstances and provide dates and diagnoses (to the best of your recollection):

Have you ever seen a psychotherapist before? If so, please provide dates and a brief explanation of the focus of your therapy:

Trauma History

Have any hardships affected you or your family?

Family Psychiatric History

Please list any mental health or substance use related issues of family members

Mother:

Father:

Maternal Grandmother:

Maternal Grandfather:

Paternal Grandmother:

Paternal Grandfather:

Sibling:

Sibling:

Medical Conditions and History

What medical issues are you dealing with, or have been significant in your past?:

What medications are you currently taking (including psychiatric)?:

What medications have you been on previously (including psychiatric)?:

Substance Use History

Have you ever been treated for substance use? If so, what were the dates?

What recreational substances do you use?

- ❑ Tobacco
- ❑ Marijuana
- ❑ Alcohol
- ❑ Pain killers
- ❑ Ecstasy
- ❑ Hallucinogens
- ❑ Cocaine
- ❑ Methamphetamine
- ❑ Heroin
- ❑ Tranquilizers
- ❑ Stimulants
- ❑ Other:_____

In what amount and frequency do you use any substances?

Family and Social History

Name of Parent/Guardian #1: _____ Phone: _____

Name of Parent/Guardian #2: _____ Phone: _____

Who do you live with? (Check all that apply)

☐ Parent/guardian #1 all the time ☐ Parent/guardian #2 all the time

☐ Parent/guardian #1 some of the time ☐ Parent/guardian #2 some of the time

Please list all other family members you live with and their age:

Are there any current or past issues with your family relationships? If yes, briefly describe:

Would you like your family to be involved in your therapy in any way? If yes, explain:

Do you have trouble making friends?

Are there any current or past issues with your social relationships?

Do you identify with a religion or spiritual practice?

What are your favorite hobbies?

Education & Occupation

What grade are you in?

What school do you go to?

Do you have a job? If yes, where?

Have you ever been suspended or expelled from school or fired from a job? If yes, why?

Legal History

Have you ever been charged with a crime? If so, briefly describe:

Have you ever been incarcerated? If so, briefly describe:

Strengths and Limitations

Please identify your top three strengths:

Please identify your top three limitations:

Additional Information

Is there anything you feel nervous or concerned about in attending therapy?

Is there anything else you want your counselor to know about you?

Thank you for your information. We look forward to working with you!