Johnson Counseling

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Confidential Client Intake Form

Please complete this form and bring it to your first session.

Name: ____ Date: ____/_____/_____

Name of parent/guardian (if client under 18): ____

Age: ___________ Date of birth: ____/_____/_____ Race/Ethnicity: _____________________

Gender identity: ______________________ Gender assigned at birth:__________________

Sexual orientation:________________________ Preferred pronouns:______________________

Marital/relationship status (circle): Single Partnered Married Separated Divorced Widowed

Significant family members – parents, siblings, children, pets, etc: (Please list name, relationship and age)

____

____

Current living arrangements: ____

Employer: _______________________________ Occupation: _______________________________

School: __________________________________ Grade level: _______________________________

Referred by/how you heard of services:____

Client Contact Information--

Client street address: ____

City: ____ State: ______________ Zip: ____________

Cell phone: ___________________________________ OK to leave a message? YES NO

Home phone: _________________________________ OK to leave a message? YES NO

Other phone: __________________________________ OK to leave a message? YES NO

Email address: ________________________________ OK to email? YES NO
(*Please note: Communication via email, cell phone or other medium is not considered confidential.)

Receive appointment reminders via text? YES NO Preferred phone(s): _______________

Emergency Contact Information---

Emergency contact name: ___________________________ Relationship to client: ____________

Primary phone: ___________________________ Other phone: _____________________________

Insurance Information (if applicable) --

Primary Insurance

Policy holder name (F, M, L):____

Policy holder address (if different from above):____

City:________________ State:_________ Zip:_________ Policy holder Date of birth: ___/___/___

Primary Insurance Company: ___________________________ Employer:___________________

Policy ID#:________________ Group #:__________________ Plan name:____________________

Secondary Insurance

Policy holder name (F, M, L):____

Policy holder address (if different from above):____

City:________________ State:_________ Zip:_________ Policy holder Date of birth: ___/___/___

Primary Insurance Company: ___________________________ Employer:___________________

Policy ID#:________________ Group #:__________________ Plan name:___________________

Client Health & Mental Health History---

Has client received previous mental health services (circle)? YES NO

Approximate number of visits, duration and year (psychotherapy or hospitalization):

____

Outcome or diagnosis of previous mental health services: ________________________________

Client currently taking or ever taken prescribed medications (circle)? YES NO

Medication name: __________________________________ Dates: _________ to __________

Medication name: __________________________________ Dates: _________ to __________

Medication name: __________________________________ Dates: _________ to __________

Prescribing or current psychiatrist (if applicable):____

Physical health

Rate client's overall health (circle): Poor Fair Good Very good

Client current physical health problems or concerns: ___________________________________

____

Current physican:____

(Health/Mental health history continued…)

History of significant injury, chronic health conditions, chronic pain, etc: ____________________

Rate client's current sleeping habits (circle): Poor Fair Good Very good

Describe any concerns/recent change in sleep patterns: ________________________________

____

Rate client's current eating habits (circle): Poor Fair Good Very good

Describe any concerns/recent change in eating habits: __________________________________

____

Any episodes of (circle any/all that apply): Binge eating Restricted eating Purging food

Do you exercise regularly? YES NO How often?: _______________________________

Type of exercise: ____

Are you currently experiencing any of the following symptoms (circle all that apply)?

Anxiety	Feeling as though the world around you is not real	Isolation from others	Questions re: (circle) Gender identity Sexuality Sexual orientation
Anger	Feelings of worthlessness	Legal issues (past or present)	Recent or past injury or physical pain
Body image concerns	Financial concerns/stress	Loneliness	Relationship problems
Depending too much on others	Frequent crying episodes	Low energy/fatigue	Restlessness
Depressed mood	Gambling in excess (or other risk-taking behavior)	Low motivation	Sadness
Difficulty concentrating	Grief or recent loss	Mood swings	Self-harm
Difficulty meeting demands	Guilt	Nightmares	Sensitivity (moderate-high) to smells, sounds, textures, visuals, other sensory experiences
Difficulty with stopping after starting certain activities	Headaches	Painful or unwanted memories or images	Sexual dysfunction/change in sexual functioning
Difficulty making decisions	Hearing voices/seeing things others don't see/hear	Panic attacks	Shame and/or embarrassment
Feeling disconnected from self	Impulsive behavior	Physical changes (e.g, weight gain or loss)	Sport performance or sport-related concerns
Feelings of inadequacy	Irritable	Problems at work	Stress

Family History--

Please identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (ex: father, grandmother, uncle, etc).

Alcohol/Substance abuse	___No	____Yes	________________________________
Anxiety	___No	____Yes	________________________________
Bipolar disorder	___No	____Yes	________________________________
Depression	___No	____Yes	________________________________
Disability	___No	____Yes	________________________________
Divorce/separation	___No	____Yes	________________________________
Domestic violence	___No	____Yes	________________________________
Eating disorder	___No	____Yes	________________________________
Obesity	___No	____Yes	________________________________
Obsessive-compulsive d/o	___No	____Yes	________________________________
Schizophrenia	___No	____Yes	________________________________
Sexual abuse	___No	____Yes	________________________________
Suicide	___No	____Yes	________________________________

Religious/spiritual background: ____

Cultural/ethnic identification: ____

Developmental History--

Achieve developmental tasks on target: ____

Highest level of education completed and where: ____

Learning concerns or problems: ____

Other: ____

History of Traumatic Incidents---

Please place a check mark beside any traumatic event(s) you have experienced and include brief description and year of event.

- O Childhood physical abuse ____
- O Childhood sexual abuse____
- O Childhood emotional abuse____
- O Physical attack (e.g., threatened, beaten up, etc)___________________________________
- O Sexual violence (rape or attempted rape, sexually assaulted, stalked, etc)__________
- O Military combat or war zone experiences_______________________________________
- O Kidnapped or taken hostage____
- O Serious accident, fire or explosion____
- O Near drowning____
- O Diagnosed with life threatening illness____
- O Natural disaster (e.g., flood, tornado, etc)_______________________________________
- O Imprisonment or torture____
- O Other (please specify): ____

Substance Use History---

Please place a check mark beside substances used and briefly describe frequency of use in the lines provided.

- O Alcohol — How much/often: ____________________
- O Recreational drug(s) — How much/often: ____________________
- O Nicotine — How much/often: ____________________
- O Caffeine — How much/often: ____________________
- O Vape/e-cigarette — How much/often: ____________________
- O Other: _______________ — How much/often: ____________________

Social History--

Client currently involved in a romantic relationship? YES NO

Rate client's current romantic relationship? Poor Fair Good Very good

Extracurricular activities/hobbies: ____

Rate client's satisfaction with current friendships: Poor Fair Good Very good

Please describe: ____

Rate client's satisfaction with family relationships: Poor Fair Good Very good

Please describe: ____

Significant life changes or stressful events experienced recently: _______________________

____

Client's perceived strengths or areas of growth:

____

Social media use – type, hours/day, days/week, purpose:_______________________________

____

Goals for Counseling--

What concerns would you like to explore during your time in counseling? ________________

____

What methods have you used to handle these concerns so far?: __________________________

____

Other information or questions not mentioned: _____________________________________

____