Stephen J. Johnson, Ph.D.

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Intake Information

Please respond as completely as possible to the following questions. You may place N/A in the response line for any that are not applicable. If there are any questions that you do not feel comfortable answering herewith, please reply R/S, will respond in session. Your responses will be maintained in complete confidentiality. Thank you for taking the time to complete this information that will be helpful in preparing for your treatment.

Name_____Date_____

Address/Street_____

City_____Zip_____

Mobile phone_____ Other? _____

Email _____ Referred by_____

Age _____ Date of birth _____

Relationship status: Single _____ Married _____ Divorced _____ Cohabitant _____

Spouse/Partner's name_____Contact Number_____

Names and ages of children_____

_____

Names and ages of siblings _____

_____

_____

Emergency contact information_____

Preferred mode of contact by therapist: Phone_____ Text _____ Email _____

Family of Origin History

Mother's name_____ Age _____

Mother's age at time of death_____ Your age then _____

Description of relationship with mother_____

_____

Father's name _____Age _____

Father's age at time of death_____ You age then _____

Description of relationship with father_____

_____

Areas of Concern

What issues/concerns have prompted you to seek treatment? Please describe_____

_____

_____

Do you have any specific goals with regard to your treatment?_____

_____

_____

Do you have any particular concerns with regard to treatment?_____

_____

_____

Psychological History

Have you ever received mental health treatment before? _____

When and for how long?_____

What was the focus of treatment?_____

Have you ever been subject to one or more psychological tests?_____

Have you ever been hospitalized for mental or emotional problems?_____

When and for how long?_____

Why were you hospitalized?_____

Are you currently taking any prescription medications? _____ Which one(s) and dosage?

_____

_____Prescribed by whom?_____

How long have you been on the medications?_____

Have you in the past or are you currently experiencing any suicidal thoughts? _____

Please describe_____

_____

Please describe your childhood_____

_____

_____

Were you ever subjected to verbal, physical, emotional, sexual abuse? Please describe

_____

_____

Have you ever been a victim of a violent crime? Please describe_____

_____

_____

Medical History

Have you ever been diagnosed with a serious illness? Please describe_____

_____

Do you have any medical conditions that may affect your mental health treatment? _____

_____

Please describe your overall health today_____

_____

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe:_____

_____

_____

Do you smoke? _____ How much? _____ For how long? _____

Do you drink alcohol? _____ On average, how much alcohol do you consume in a week?

_____

Do you currently use recreational drugs? Please describe your use _____

_____

Have you ever been dependent on substances or medications? Please describe_____

_____

Have you ever been in a 12-step program? Please describe _____

_____

_____

Additional Information

Please describe your spiritual or religious preference and history_____

_____

Please describe your interests/hobbies _____

_____

_____

Please feel free to include any other information that you believe is relevant to your mental health treatment, not previously requested_____

_____

_____

_____

Thank you. This information will be kept completely private.