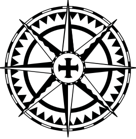

Pamela Johnson, LMFT

Date_______________

Intake Form

Client's Name First Name ______ Middle ______ Last ______ Male / Female

Spouse's Name First Name ______ Middle ______ Last ______ Male / Female

Address ______________________________

City ____________________ **State** ________ **Zip** ____________

Home Phone (   ) ____________ **Work Phone** (   ) ____________ **Cell Phone** (   ) ____________

Date of Birth ____/____/____ **Marital Status** Single Married Other

Highest Level of Education ______________ **Religious Affiliation** ______________

Occupation / Business ______________________________

How did you hear about me? ______________________________

Personal & Family History:

Client's Immediate Family Members:

Name	Relationship	Age		Name	Relationship	Age

Please describe any history of physical or mental health issues either in your current family or in your family of origin:

____

Any history of addictions? Yes No Give Details: ______________________________

Have you ever had psychotherapy before? Yes No Reason: ______________________________

Name of Therapist: ______________________________ Dates: ______________

Are you currently on any medications? Yes No

Medication:		Prescribed By:		Dosage:		Date(s) of usage:	
Medication:		Prescribed By:		Dosage:		Date(s) of usage:	

Any significant health changes in the past year? Yes No Reason:

What brings you to therapy at this time?

Notice of Privacy Practices,
Payment & Cancellation Policies
Receipt and Acknowledgment of Notice

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Pamela Johnson's Notice of Privacy Practices, Payment & cancellation policies. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Pamela Johnson at 847-381-2700 x111 or 1531 South Grove, Suite 204, Barrington, IL 60010

Signature of Patient / Client Date

Signature of Parent, Guardian or Personal Representative* Date

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Patient / Client Refuses to Acknowledge Receipt:

Signature of Staff Member Date