**Julie Johnson, MA, LCPC** **2656 W. Montrose Ave Suite 105 Chicago, IL 60618**
**Licensed Clinical Professional Counselor** **773-383-7033 www.juliejohnsonlcpc.com**

CLIENT INTAKE FORM

Name: _____ Today's Date: _____

Address, City, State, zip code _____

Phone Number:_____Marital Status:_____

Date of Birth:_____ Email Address:_____

Where do you prefer to be contacted? phone, email_____

Is it okay to leave voice message?_____ Is it okay to send you appointment reminders_____

Is it okay to send mail at above address?_____If not, please provide address where you want any correspondence to be sent_____

Referred by/Referral Source:_____

Emergency Contact name and phone number:_____

Who is your employer:_____Position/title:_____

**Insurance information:** Please complete this section if you are utilizing insurance. A copy of your insurance card and photo ID will be needed.

Insurance company/provider:_____ PPO or HMO_____

Insured Name:_____Relationship to insured:_____

Insured phone and address if different from above: _____

Insured ID/Subscriber ID #_____Insured Date of Birth_____

Group Number:_____Effective Date: _____

Deductible and co-pay amount: $_____

Insurance company address and phone number:_____

Send Claims to:_____

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Describe briefly what brings you in for counseling/therapy?

What are your goals for therapy?

Have you ever been in therapy before? If so when and where and how was it?

Have you ever experienced a traumatic event?

Childhood physical/sexual abuse?

Sexual Assault?

Domestic violence?

Other traumatic events, or violence?

Who lives in your household and describe those relationships?

Briefly describe your support system? Social, friendships, hobbies, interests and activities?

Do you have any medical issues? If so, what are the medical issues?

Are you currently taking any medications? If so, what are they, dosage, prescribing physician and what are they being taken for?

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Do you have any history of taking medications? If so, what were they and why were they discontinued?

Have you ever been hospitalized for any reason? If so, why? Medical, mental health, other?

Have you ever attempted suicide? If so, how many times, and when?

Are you currently having any suicidal thoughts, feelings or behaviors? If yes, please explain:

Do you have any history of or current homicidal or violent thoughts, feelings or behaviors, or anger control problems? If yes, please explain:

Any current threats of significant loss or harm (illness, divorce, job loss, abusive environment) If yes, please explain:

Briefly describe the symptoms you are experiencing and how long you have been experiencing these symptoms? For Example: depressed, anxious. Any difficulties with sleep, appetite?

Are you currently working with any other health care providers? If so, who and what are you seeing them for?

Do you have any history of drug or alcohol use/abuse? If so, what type of drugs or alcohol did you use?

Are you currently using any drugs or alcohol? If so, what are you using?