

HOLLY LEA JOHNSON MA, LMFT



Today's Date: _____ Referred By: _____

Client Name _____ Birth Date _____ Age _____

Address _____ Phone Number _____ Text Y N _____

City/Zip Code _____ Email Address _____

Insurance information _____ Member ID # _____

Group # _____ Authorization # _____

CURRENT ISSUE

What brings you to counseling at this time, please be as specific as possible

IF CLIENT IS A MINOR

If Client is a Minor, Parents Names and contact information

If Parents are divorced what are the custody agreements/ court orders

*If there is joint custody I will need a signed **Consent to Treat a Minor** signed from both parents, will you be able to provide me with this prior to treatment

Name of your child's school and current grade level

How is your child currently doing in school with their grades?

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How is your child doing socially/Friendships?

Names and ages of siblings

Does your child have and IEP/diagnosed learning disabilities

If yes, what is the diagnosis?

ADULT/COUPLES

Relationship Status

If Married/Partnered; Name of Significant Other

Family Composition

Relevant family and childhood history

EDUCATION/EMPLOYMENT INFO

Last Grade Completed

Occupation

How Long

Employer

How Long

Have you been unable to work, if so when and how long

Do you frequently miss work?

Did you serve in the military?

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What is your cultural, ethnic background _____

Spiritual Beliefs _____

List your siblings from oldest to youngest and their current ages _____

Did your parents live together through your childhood, if not what happened and how old were you _____

Where did you grow up? _____

Any special problems in your family _____

Hospitalizations _____

Disabled child _____

Serious medical illness _____

Death in the family _____

Alcohol/drugs _____

Domestic violence/parents fought _____

Parents unemployed _____

Legal problems _____

What were you like as a child? _____

Had problems learning _____

Got into trouble in school _____

Had problems with the law _____

Felt like you didn't belong _____

Fought with your parents _____

Isolated yourself from the family _____

Physically abused _____

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Emotionally abused _____

Sexually abused _____

Had too much responsibility _____

Please add anything else about your childhood, what is your current relationships with your family members

Have you seen a therapist before _____ Name of Therapist _____

Why did you discontinue therapy with prior therapist? _____

Have you ever been hospitalized 51/50'd _____ When _____

Where _____ how long _____

Any current medical problems _____

Please list current medications _____

Non-prescription substances you use (d) including alcohol, tobacco, amphetamines, cocaine, marijuana, heroin or others _____

Does anyone living with you use any of these substances? _____

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What do you hope to gain for yourself during our time together, what goals/dreams do you have

What brings you happiness and joy?

What are you grateful for in your life?

Any recent significant life events, not listed anywhere above

Are you currently having any suicidal/homicidal thoughts/plans?

Are you currently experiencing any domestic violence?

In the even of an emergency, who do you authorize me to contact:

Name _____

Phone Number _____

Relationship to you _____