Jason A Johnson, Psy.D.

Clinical Psychologist

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Client Information

Date: _____

Name: _____ Preferred Name: _____

Date of Birth: _____ SSN: _____

Gender: _____ Sexual Orientation: _____

Preferred Pronouns: _____

Ethnicity/Cultural Background: _____

Highest Level of Education: _____ Occupation: _____

Contact Information

Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers:	Ok to leave a message?	
Home: _____	☐ Yes / No ☐	☐ Primary Contact
Work: _____	☐ Yes / No ☐	☐ Primary Contact
Mobile: _____	☐ Yes / No ☐	☐ Primary Contact
Other: _____	☐ Yes / No ☐	☐ Primary Contact
Email: _____	☐ Yes / No ☐	☐ Primary Contact

Emergency Contact

Name: _____ Phone #: _____

Relationship: _____ I give permission to Jason A. Johnson, PsyD, LLC to contact this person in an emergency: _____ (initials)

Current Concerns

Please describe the concerns that lead you to seek therapy: _____

_____

_____

_____

What have you tried to do to solve the above concerns? _____

_____

What in the past has been helpful in reducing these concerns? _____

_____

Have you ever received psychiatric or psychological help of any kind before? ◯ Yes ◯ No

If yes, who have you seen before?

Therapist	Date	Purpose	Was it helpful?
_____			☐ Yes ☐ No
_____			☐ Yes ☐ No
_____			☐ Yes ☐ No

Have you ever been hospitalized for mental heath reasons? ☐ Yes ☐ No

Have you ever had thoughts, made statements, or attempted to hurt yourself? ☐ Yes ☐ No

Have you ever had thoughts, made statements, or attempted to hurt someone else? ☐ Yes ☐ No

Have you ever had any of the following experiences?

- ☐ Crime victim
- ☐ Emotional abuse
- ☐ Homelessness
- ☐ Life threatening illness
- ☐ Were adopted
- ☐ Lived in a foster home
- ☐ Loss of loved one
- ☐ Multiple family moves
- ☐ Neglect
- ☐ Parental substance abuse
- ☐ Physical abuse
- ☐ Placed a child for adoption
- ☐ Serious auto accident
- ☐ Sexual abuse or assault
- ☐ Violence in the home
- ☐ Difficult immigration
- ☐ Life threatening violence (including combat)
- ☐ Other: _____

Family History of Mental Health Issues:

Family Member	Issue(s)	Diagnosed or Suspected?
		☐ D / S ☐
		☐ D / S ☐
		☐ D / S ☐
		☐ D / S ☐
		☐ D / S ☐

Do you have a primary care physician? _____

Address: _____

Phone #: _____ FAX: _____

Date of last medical visit to your primary care physician: _____

List any major health concerns for which you are currently receiving treatment: _____

_____

_____

Any allergies or adverse reaction to medication or treatment? ◯ Yes ◯ No

If yes, please describe: _____

List any medication or over the counter medications you are currently taking:

Name of medication	Dosage	Frequency	Prescribed by	Date Started
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you struggling with any of the following?

- ☐ Aggression
- ☐ Alcohol or drug use
- ☐ Anxiety/ worry
- ☐ Body image concerns
- ☐ Change in appetite
- ☐ Compulsive behaviors
- ☐ Crying spells
- ☐ Distractibility
- ☐ Eating problems
- ☐ Fatigue
- ☐ Feeling suicidal
- ☐ Gambling problems
- ☐ Guilt/shame
- ☐ Hallucinations
- ☐ Hearing voices
- ☐ Hopelessness
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Irritability
- ☐ Loneliness
- ☐ Loss of pleasure
- ☐ Low self-worth
- ☐ Memory difficulties
- ☐ Nightmares
- ☐ Obsessive thoughts
- ☐ Overuse of Internet
- ☐ Panic attack
- ☐ Parenting problems
- ☐ Racing thoughts
- ☐ Relationship problems
- ☐ Sadness
- ☐ Self-harm
- ☐ Sexual problems
- ☐ Sexual identity problems
- ☐ Sleep problems
- ☐ Suspicion/paranoia
- ☐ Thoughts of death
- ☐ Thoughts of harming others
- ☐ Wide mood swings
- ☐ Work/school problems
- ☐ Other: _____
- ☐ Other: _____

Please list your top three concerns: _____

_____

Are your current problems affecting any of the following?

- ☐ Exercise
- ☐ Finances
- ☐ General Health
- ☐ Handling Everyday Tasks
- ☐ Housing Relationships
- ☐ Hygiene
- ☐ Legal Matters
- ☐ Sexual Functioning
- ☐ Recreational Activities
- ☐ Self-esteem
- ☐ Sexual Activities
- ☐ Spirituality/faith

Social Networking

Relationship Status:_____ Length of Current Relationship: _____

Do you feel safe in your current relationship? ◯ Yes / ◯ No

How satisfied are you with your marriage/relationship? (circle #)

Extremely Dissatisfied	1	2	3	4	5	6	7	Extremely Satisfied

How satisfied are you with your relationship with your spouse/partner? (circle #)

Extremely Dissatisfied	1	2	3	4	5	6	7	Extremely Satisfied

How satisfied are you with your partner as a spouse/significant other? (circle #)

Extremely Dissatisfied	1	2	3	4	5	6	7	Extremely Satisfied

How satisfied are you with your sex life in your current relationship? (circle #)

Extremely Dissatisfied	1	2	3	4	5	6	7	Extremely Satisfied

Number of Children: _____ Age(s) and gender of Children: _____

_____

Please describe your social/support system: _____

_____

What do you do to relax or for fun? _____

_____

Substance Use/Abuse

Please describe your caffeine intake: _____

Please describe your alcohol use: _____

Alcohol use in the past: _____

Has anyone currently or in your past expressed concerns over your alcohol use? ◯ Yes ◉ No

Do you currently use any drugs that are not prescribed by a medical doctor? ◯ Yes ◉ No

Please describe any current or past drug use including cocaine, crack, ecstasy, heroin, inhalants, marijuana, methamphetamines, pain killers, PCP/LSD, steroids, tobacco, tranquilizers or other:

_____

_____

_____

Have any family members had problems with alcohol or drugs? ◯ Yes ◯ No

Expectations

What do you hope to get out of counseling, what would you like to see change in your life?

_____

_____

_____

Thank you for providing me with this valuable information. Your responses here will help guide our initial session and inform our ongoing therapy.