Joni Johnson, MA, LMFT
Licensed Marriage and Family Therapist

Name: _____ Date: _____
Birthdate and age: _____
Address: _____ Phone number: _____

Reason for seeking therapy: _____

_____

Please check all that apply: ( ) Married 1x 2x 3x 4x ( ) Widowed ( ) Never Married
( ) Separated ( ) Divorced ( ) Living Together

Household members: (Names, ages, relationship)

_____

_____

Any children not living at home? _____

Who do you consider your support system? _____

_____

Who do you give permission to call in case of an emergency?_____
Relationship: _____ Phone number: _____

Occupation and length of employment: _____

If applicable, describe the role of religion or spirituality in your life: _____

_____

Previous Therapy Experience: (when, how was the experience, and what was the goal?)

_____

_____

Any psychiatric hospitalizations, and if so when? _____

Any intention of hurting yourself? _____

Medical Doctor: _____ Phone number: _____

When was your most recent complete physical? _____

Any current or past medical problems that are impacting the present? _____

_____

Please list all current medications, dosage, and purpose: _____

_____

Alcohol use (quantity and frequency): _____

Goal(s) for therapy (desired outcome): _____

_____