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Intake Evaluation

Today's Date _____ Referred by _____
Type of Services sought Individual adult Individual child Individual teen Family
 Couple Co-parenting Parent coaching Supervision Sandplay process

Name _____ DOB _____

Address _____

City, State, Zip _____

(Please circle number you prefer that I call and where it's okay to leave a voice mail message for you)

Home phone _____ Mobile phone _____

Name of emergency contact _____ phone _____

National and/or ethnic origin _____

Gender: Female Male Height _____ Weight _____ Married Separated Divorced

Spouse's name _____ DOB _____

Occupation _____ Employer _____

Training and Employment

Occupation _____ Business phone _____

Employer/Business/Source(s) of income _____

Academic education and/or Occupational training:

Physical and Mental Health History

Rate your physical health: Physically fit Very good Average Poor

Approximate date of last physical exam _____ Any health concerns? Yes No

If so, please describe:

List medications being taken currently and describe purposes and dosages:

Your physician _____ Phone _____

Physician Address _____

List and date important illnesses, surgeries or injuries, including complicating events:

Previous counseling, psychotherapy or analysis? Yes No Was it useful? Yes No

Name(s) of professional(s) engaged, approximate dates and time span of therapy and why it was useful or not:

Have you ever been or are you now being mistreated or abused? Yes No

verbally/emotionally physically sexually other. Please describe:

Have you ever been or are you now drug or alcohol dependent? [] Yes [] No
If yes, please describe:

Have you ever witnessed or been involved in a traumatic event(s)? [] Yes [] No
If yes, please describe briefly:

Previous serious mental/addictive disturbance or "nervous breakdown"? [] Yes [] No
If yes, were you hospitalized? [] Yes [] No For how long? _____
Psychiatrist name _____ Facility/Hospital _____
Comments:

Marital History

Marital status _____ years married _____ years separated/divorced _____

Children of current marriage

Name	Age	Gender	Comments
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Former spouse's name(s) _____ Age(s) _____

Dates of marriage _____ to _____ Age when married _____

Comments:

Children of previous marriage(s)

Name	Age	Gender	Parents	Comments
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Family History

Please create on the back of this page a **3-generation map** (include yourself, spouse, your siblings; your children, parents and their siblings, grandparents; illnesses, deaths, life challenges; please also include relatives and step-relatives who live in your household now).

Therapeutic Work

What is your favorite myth, legend or fairy tale and who is your favorite hero? As a child?

What are the challenges, concerns or problems you would like to address in therapy?

What do you hope to accomplish by engaging in therapy?