Leslie Johannes, MEd, LMFT, CST-T
Jungian Psychotherapy, Personal, Relationship and Sandplay Therapy
AAMFT Approved Supervision
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Intake Evaluation

Today's Date________________ Referred by____

Services sought [ ] Individual adult [ ] Individual child [ ] Individual teen [ ] Family [ ] Couple [ ] Co-parenting
[ ] Parent coaching [ ] Supervision [ ] Personal Sandplay process

Personal and Contact Information

Name____ DOB_________________________

Address, City, State, Zip____

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

Home/Mobile phone ____________________________ Email ____

National and/or ethnic origin (optional)____

Gender [ ]Female [ ]Male [ ] **Other**____

Marital Status [ ]Single [ ]Years Partnered or Married [ ]Years Separated [ ]Years Divorced

Name/relationship of emergency contact ____EC Phone_______________

Your Training and Employment

Occupation____ Business phone _______________________

Employer/Business ____
Academic education and/or Occupational training:

Physical and Mental Health History

A. Physical health self-rating: [ ] Physically fit [ ] Very good [ ] Average/OK [ ]Poor

Approximate date of last physical exam___________________ Any health concerns? [ ] **Yes** [ ] **No** If "Yes", please describe:

Your physician ____ Phone ________________________

Physician Office Address ____
List medications being taken currently and 1) describe purposes and 2) include dosages:

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

B. Psychotherapy or analysis previously engaged in **[ ] None [ ] Once [ ] More than once**
1)Name(s) of professional(s), 2) approximate dates, and 3) years in therapy. *Please include if it was useful and why or why not:*

Have you ever been or are you now being mistreated or abused? [ ] Yes [ ] No [ ] Not sure
[ ] Verbally/Emotionally/Mentally **[ ]** Physically **[ ]** Sexually **[ ]** Other
If yes, please describe:

Have you ever been or are you now dependent on substance(s)? [ ] Yes [ ] No [ ] Not sure
If yes, please describe:

Have you ever witnessed or been involved in a traumatic event(s)? [ ] Yes [ ] No [ ] Not sure
If yes, please describe briefly:

Have you had a serious mental/addictive disturbance or "breakdown"? [ ] Yes [ ] No [ ] Not sure

If yes, were you hospitalized? **[ ] Yes [ ] No** For how long? ______________

Psychiatrist name____ Facility/Hospital_________________________________
Circumstances/Comments:

Marital/Parenting History
Spouse's/Partner's name____ DOB__________________

Occupation____ Employer ____

Children of current marriage/partnership

Name	Age and Gender	Comments (step or bio)

+ +

Former Spouse's name ____ DOB __________________

Dates of marriage _______________________ to ____________________ Your Ages when married ___________________
Comments

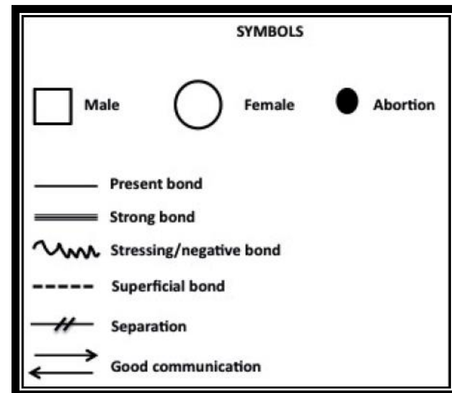
Children of previous marriage(s) and former spouse/partner names

Name	Age and Gender	Partner Name	Comments (step or bio)

Family History (Family of Origin – FOO)

Please create here or on the back of this page a **3-generation family tree or map**.

You may want to consider using these symbols:



Please include:

- *yourself, your spouse, your siblings, step parents and step siblings*
- *your children*
- *your parents and their siblings, step siblings, spouses*
- *grandparents, spouses*
- *moves, divorces, illnesses, deaths, life challenges as they occurred for each person*
- *please also include relatives and step-relatives who live or have lived in your household*

Therapeutic Work

What are your favorite stories, movies, myths, legends, or fairy tales? Now and as a child

Name personal hero(s) or heroine(s) – mythical, literary, or real life experiences – and explain their significance

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

What do you hope to accomplish by engaging in therapy?

What concerns or hesitations do you notice as you consider engaging in therapy?