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Jungian Psychotherapy, Personal, Relational 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 _____

Name of emergency contact _____ EC Phone _____

National and/or ethnic origin _____

Gender and physical characteristics Female Male HWP Over or Under Weight (medically defined)

Marital Status Single Years Partnered or Married Years Separated Years Divorced

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 describe purposes and dosages:

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

b. Psychotherapy or analysis previously engaged in None Once More than once
Name(s) of professional(s), approximate dates and 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
 Verbally/Emotionally/Mentally Physically Sexually Other
 If yes, please describe:

Have you ever been or are you now dependent on substance(s)? 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:

Have you had a serious mental/addictive disturbance or "breakdown"? Yes No
 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 and current spouse/partner

Name	Age and Gender	Comments (step or bio)
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Former Spouse's name _____ **Age** _____

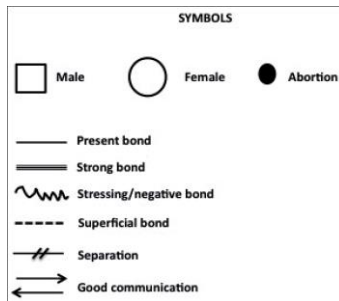
Dates of marriage _____ to _____ Your Age when married _____
 Comments:

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

Name	Age and Gender	Partner Name	Comments (step or bio)
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Family History (Family of Origin – FOO)

Please create 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?

... as a child?

Name personal hero(s) or heroine(s) – may be mythical, literary, or real – 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?