Sarah Johnston, MSW, LICSW
sarahjohnstontherapist@gmail.com Licensed Independent Clinical Social Worker
612-440-5707 1854 Grand Avenue #200
St. Paul, MN 55105

Client Intake Packet

Thank you for completing this form. It enables me to better assist you on your path of growth or healing. This form will be stored securely in your confidential file.

I look forward to working with you!

Full legal name _____
Date_____

Preferred name _____ Preferred pronouns_____

Date of birth_____ Age___ Gender_____ Relationship status_____

Complete Home
Address_____

At least one phone number where I may contact you:

_____ (circle:) home/work/cell Okay to leave a message? ___ yes ____no

_____ (circle:) home/work/cell Okay to leave a message? ___ yes ____no

Education:

Occupation:

Employer:

Emergency Contact: Name_____ Phone_____

Relationship_____

Name and address of person responsible for payment: _____
_____

If applicable Third-party payer/ Insurance company name and address:

_____

Insurance ID number _____

Insurance group number _____

Name of policyholder (if different than above) _____

Relationship _____

How did you find me?

__ Referred by someone (name & relationship)
_____

__ Online directory _____

__ My website

__Other _____

Current Concern

What brings you to seek therapy, and why now?

Health & Therapy History

Please share previous therapy/ mental health treatment experiences, if any.

Do you have any current physical health concerns? Any major health experiences to share?

Please list any medications you are currently taking.

Have you taken medication in the past for mental health concerns?

Please list other care providers with whom you are currently working. This might include a psychiatrist, medical doctor, acupuncturist, midwife, etc.

Family Information (use the back of the page if you need more room)

List current partner/ spouse, children, and roommates or others in your current household

Name	Relationship	Gender	Current Age

Please list any other important or supportive people in your life.

Any concerns about your current living situation or environment?

Please list your family of origin; also list significant members in your household while growing up:

Name	Relationship	Gender	Still living? yes/ no	Current age (or age at death)

Significant deaths of other family members (not shown above) or of other important relationships:

Have you or your family members experienced the following? Check where applicable:

	You		Family Member	
	Past	Present	Past	Present
Alcohol/ drug abuse or dependency				
Physical Abuse				
Sexual Abuse				
Emotional/ Verbal Abuse				
Persecution for racial/ ethnic/ or sexual identity				
Suicide attempts or completed suicide				
Significant and persistent mental illness				
Chronic or significant physical illness				
Traumatic birth experiences				
Postpartum depression or anxiety				
Any other traumatic experiences				

Personal Strengths and Background

What are some positive personal qualities or strengths that you or others would say you have?

What are some things you appreciate, or are proud of, about yourself?

What are the top challenges you are managing right now?

Describe your current support system: (i.e., where you obtain support for your physical, emotional, and spiritual health). Examples would be: physical exercise & relaxation, involvement with family & friends, support group, spiritual community; experiences with nature, recreational activities, etc.

Do you have any specific religious or spiritual beliefs? If so, please describe:

How important is spirituality in your life? low———————high

How do you describe your racial, ethnic, and/ or cultural background?

How important is your ethnic or cultural heritage to you? low———————high

How do you describe your sexual orientation?

Symptoms and Daily Functioning

Please rate the severity of the following symptoms over the last month:

None———————————————Severe

0	1	2	3	4	5	Depression
0	1	2	3	4	5	Anxiety or agitation
0	1	2	3	4	5	Sadness
0	1	2	3	4	5	Irritability or anger
0	1	2	3	4	5	Loss or Grief
0	1	2	3	4	5	Guilt
0	1	2	3	4	5	Feelings of emptiness or apathy
0	1	2	3	4	5	Mood swings
0	1	2	3	4	5	Confusion or indecision
0	1	2	3	4	5	Poor memory or concentration
0	1	2	3	4	5	Loneliness
0	1	2	3	4	5	Low self-esteem or self neglect
0	1	2	3	4	5	Obsessive thoughts
0	1	2	3	4	5	Panic, fears, or phobias
0	1	2	3	4	5	Stress related to trauma
0	1	2	3	4	5	Sleeping more or less than usual
0	1	2	3	4	5	Eating more or less than usual
0	1	2	3	4	5	Weight loss or gain
0	1	2	3	4	5	Concerns about sexual health
0	1	2	3	4	5	Gambling or compulsive spending

0	1	2	3	4	5	Concerns by you/others about alcohol/ drug use
0	1	2	3	4	5	Concerns by you/others about other compulsive behaviors
0	1	2	3	4	5	Problems related to experiences of abuse Circle: physical/ sexual/ emotional/ verbal
0	1	2	3	4	5	Thoughts or actions of hurting yourself
0	1	2	3	4	5	Thoughts or actions of hurting others

Rate your satisfaction with (or the quality of) these areas of your life:

Very good	Good	Neither good nor poor	Poor	Very poor	
					Relationship with yourself
					Romantic/ partner relationships
					Family relationships
					Friendships
					Community (being a part of sharing/ giving to others)
					Spirituality
					Job/ career or school
					Finances
					Physical health
					Sexual health
					Living environment

Anything else that is important for me to know?

Client Signature_____ Date _____

This form will be stored securely in your confidential file.