



SHANNON JOHNSON LPC  
PSYCHOLOGY

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**Adult Client Intake Form**

**Client Information**

Date: \_\_\_\_\_

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Phone Numbers: \_\_\_\_\_  
Home Work Cell

Email: \_\_\_\_\_ Preferred Contact Number: **Home Work Cell**

SS# \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_

**Spouse/Partner Information**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Phone Numbers \_\_\_\_\_  
Home Work Cell

Email: \_\_\_\_\_ Preferred Contact Number: **Home Work Cell**

SS# \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_

**Insurance Information**

Company: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_

Policyholder: \_\_\_\_\_ ID#: \_\_\_\_\_

Address of Co.: \_\_\_\_\_

Insurance Phone #: \_\_\_\_\_

**Assignment of Benefits:** "I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of benefits to Shannon L. Johnson, LPC for the services provided."

\_\_\_\_\_ signature

\_\_\_\_\_ date

**Client Health History**

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Describe significant present or past illnesses, injuries, or handicapping conditions:

Chronic Illness: \_\_\_\_\_

Terminal Illness: \_\_\_\_\_

What medications are you currently taking?

Medication	Dosage	Purpose

Have you ever had or are you currently having thoughts of:

Hurting yourself \_\_\_\_\_ Hurting someone else \_\_\_\_\_

Not wanting to live \_\_\_\_\_ Suicide attempt \_\_\_\_\_

Have you seen a therapist for any of these issues in the past or present? **Yes No**

Have you ever been hospitalized for mental health concerns? **Yes No**

Please explain:

\_\_\_\_\_

**Family History**

Family Information (or other household members)

Name	Sex	Age	Relationship	Live At Home (Y/N)

Current Family Stressors

- \_\_\_ Chronic illness of family member
- \_\_\_ Death of significant person
- \_\_\_ Divorce or separation
- \_\_\_ Domestic Violence
- \_\_\_ Family member absent
- \_\_\_ Family member emotional problems
- \_\_\_ Family member suicide
- \_\_\_ Financial problems/job loss
- \_\_\_ Frequent moves

\_\_\_ Other

Family history of emotional/behavioral problems, substance abuse, family violence, or criminal activity?      **Yes**                      **No**                      If yes, please explain:

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**Current Concerns**

Please indicate the following items that apply:

- \_\_\_ Abuse (physical, emotional, sexual)
- \_\_\_ Adjustment to life changes
- \_\_\_ Drug or alcohol use
- \_\_\_ Eating problems
- \_\_\_ Family or step family relationships
- \_\_\_ Feeling angry or irritable
- \_\_\_ Feeling anxious
- \_\_\_ Feeling sadness or depression
- \_\_\_ Health concerns
- \_\_\_ Illegal behaviors
- \_\_\_ Non-family relationship problems
- \_\_\_ Parent-Child relationships
- \_\_\_ Birth of child
- \_\_\_ Suicidal thoughts or attempts
- \_\_\_ Unusual behavior/changes in behavior
- \_\_\_ Other significant life events. Please explain:

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Is anyone hurting you now? **Yes** **No** Please explain:

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Please state the kind of alcohol and the frequency you consume alcohol, if any: \_\_\_\_\_

Please state if you smoke marijuana or use other "street drugs" (this information is strictly confidential): \_\_\_\_\_

**Briefly describe the problem that has brought you to therapy:**

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**What are your goals of therapy:**

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**Emergency Contact Information**

Emergency Contact Person (other than household member)

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

May I contact this person in the event of an emergency?    **Yes**   **No**

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**Signature**