



CLIENT INTAKE FORM

Darrell R. Johnson, Ph.D.

File number: _____

Today's date: ____/____/____
(Day) (Month) (Year)

YOUR INFORMATION

You (1): _____

Client (2): _____

Client (3): _____

Client (4): _____

Gender:

Male Female

Language:

English French

Male Female

English French

Male Female

English French

Male Female

English French

Birthdates:

(1) ____/____/____
(Day) (Month) (Year)

(2) ____/____/____
(Day) (Month) (Year)

(3) ____/____/____
(Day) (Month) (Year)

(4) ____/____/____
(Day) (Month) (Year)

Civil status (1): single cohabitant married separated divorced widowed

Address: _____

Email: _____

Website: _____

OK to leave messages? Hours:

Telephone: () _____ (home) _____
() _____ (work) _____
() _____ (cell) _____
() _____ (other) _____

Referral Source:

- Re-user
- Friend/ family member
- DRJOHNSON Website
- Other Internet Site
- Family Doctor
- Psychiatrist
- CLSC
- Other Psychologist
- School
- Other agency

Contact person:

Telephone:

_____ () _____
_____ () _____
_____ () _____
_____ () _____
_____ () _____
_____ () _____

YOUR AVAILABILITY

Best days:	Monday	Tuesday	Wednesday	Thursday
Best times:	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

(Please give several possibilities: sessions begin on the hour)

(Montreal office: Tuesday and Thursday; South Shore office: Monday and Wednesday)

YOUR INITIAL TREATMENT GOALS

Your reason(s) for consulting:

Your initial goals or expectations (if any are clear to you at this time):

Type of therapy you desire:

- Individual Couple Family Child or Adolescent Parent Coaching Not yet determined

Any questions you might have for me at this point:

(Your signature)