Principal Office:
751 Hebron Parkway, Ste. 305D
Lewisville, TX 75057
469-549-4200
469-549-4201 (fax)
www.johnsonneuro.com

Satellite Offices:
2031 John West Rd., Ste 120
Dallas, TX 75228

~ Welcome ~

Please read and complete the enclosed forms. Please note any questions that you would like to discuss at our intake meeting.

1. **Client Registration**
2. **Office Policies and Consent to Treatment**
3. **Intake Questionnaire**

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CLIENT REGISTRATION FORM

Name: _____ DOB: ___/___/____ Age: _____

Residential Address: _____ City: _____ Zip: _____

OK to send treatment/billing information to this mailing address? Yes No

If no, please provide an alternative mailing address: _____

Home Phone: _____ Messages OK? Yes No

Cell Phone: _____ Messages OK? Yes No

Other phone: _____ Messages OK? Yes No

Relationship Status: Single * Married * Committed Relationship * Divorced * Separated * Widowed * Other

Emergency Contact: Name_____ Relationship to you: _____

Home phone: _____ Other phone: _____

Primary Care Physician: _____Phone:_____

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Office Policies and Informed Consent

Welcome! This document contains important information about my professional services and business practices and will serve as a therapeutic contract. Please read it carefully and jot down any questions you would like to discuss. Please let me know if you would like to receive a copy of this signed form for your own records

About the Therapy Process

It is important for you to know that therapy has both benefits and risks. Therapy often requires recalling unpleasant events and struggling with troubling issues. Consequently, people sometimes experience uncomfortable feelings such as sadness or loneliness. However, therapy has been shown to have benefits for those who undertake it. Although there are no guarantees about the outcomes of therapy, people often report significant reductions in feelings of distress, satisfactory resolution of specific problems and an improvement in relationships and overall quality of life.

Cancellation Policy

A 24 hour notice is required for changes in appointments. Late cancellations and no-shows are still billed.

Therapist Availability & Emergency Procedures:

- Telephone consultations between office visits are welcome. However, I will attempt to keep those contacts brief due to my belief that important issues are better addressed within regularly scheduled sessions.
- You may leave a message for me at any time on my **confidential voicemail at: (469) 469-4200.** On weekends and holidays, I check my messages less frequently and may only respond to urgent calls. Non-urgent phone calls are generally returned within 24 hours. If you have an urgent need to speak with me, please indicate that fact in your message. I will return your call at my earliest opportunity.
- Our office is *not* an emergency number. In the event of a mental health crisis, please call the **24 hour Crisis Line at 940-320-8100**. You may leave a message

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on my voicemail regarding the situation and I will get back to you as quickly as possible.

- **In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.**
- Vacation: I will inform you in advance of my vacation schedule. I will arrange for coverage by another therapist when I am out of the office for vacation or business.

CONFIDENTIALITY:

In most cases (see "Exceptions to Confidentiality" below) communications between client and therapist will be held in strict confidence - unless you provide your therapist written permission to release information about your treatment. If you participate in couples or family therapy, the therapist will not disclose confidential information about treatment to a third party (other than to a third-party payer) unless all treatment participants (18 or older) provide written authorization to release such information.

Exceptions to Confidentiality
Therapists are legally-mandated to report all known or suspected instances of child abuse, dependent adult abuse and elder abuse. Therapists are also required to break client confidentiality when it has been determined that a client presents a serious danger of physical violence to another person. A therapist may break confidentiality when she feels you are at high risk for a safety threat with regard to suicidal or homicidal ideation.

Consultation: I may consult with other professionals regarding my clients; however, my client's identity remains completely anonymous, and confidentiality is fully maintained.

In my absence: At times, I may need to reveal your name and phone number to particular therapists covering my practice in my absence.

E - Mail Cell Phones, Computers and Faxes:
Individuals may choose to contact me via email, fax or cell phone. In doing so, they agree to the understanding that email, fax and cell phone communication are not guaranteed confidential methods of communication, and they are, by choice, relinquishing their rights of confidentiality.

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Consent to Treatment:

Your signature below indicates that you have had the opportunity to read and review the information in this three page document and that questions regarding your care have been satisfactorily answered. Furthermore, it indicates your willingness to abide by its terms and that you agree to participate in treatment. A copy of this document will be provided at your request.

Client signature

_____Date_____

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INTAKE QUESTIONNAIRE

Name: _____

What brought you into therapy today?_____

_____

What do you wish to change or accomplish as a result of therapy? _____

_____

Have you been in therapy before? Yes No If yes, please state when and where:

_____

Was it a positive experience? Yes No What did you like/not like about it?

_____

Reflecting on the last 6 months, please circle all that apply:	
Frequently sad or depressed	Feeling restless or keyed up
Overwhelming worries	Restless unsatisfying sleep
Difficulty falling asleep or staying asleep	Muscle tension
Unable to concentrate	
Irritable and/or short temper	Mood Swings
Significant change in weight	Decreased need for sleep (only need 3-4 hrs)
Low energy level/fatigue	Feel more talkative than usual
Feeling excessive guilt or shame	Excessive spending/shopping
Unable to relax	Excessive gambling
Lack of appetite/increased appetite	Easily distracted by unimportant things
Loss of interest in activities/hobbies	Take too many risks
Feeling hopeless	
Feeling worthless	
Difficulty motivating	Troubling thoughts about the past
Withdrawn/isolating self	Nightmares
Cry easily/often	Startle easily
Difficulty making a decision	Too neat and orderly
Difficulty finishing tasks	Repeating certain behaviors over and over
Thoughts to hurt self	Easily upset or angered
Attempts to harm yourself	Feeling different from most people
Thoughts to hurt others	Shy around others

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Threats to hurt others	Increasingly forgetful
	Strong fears
Feeling ill/sick	Difficulty with work or school
Stomach aches/vomiting	
Headaches/migraines	Use of sedatives

Medical History

Have you consulted a physician or psychiatrist regarding the problem which brings you here? No Yes _____

Are you currently being treated for any medical problems? Yes No

Are you currently taking any medications? Yes No

List medications:

Dosage	Type	For (i.e. depression)	Prescribed by

Are you currently taking over the counter medications, herbs or supplements? Yes No

Are you presently in good health? Yes No

Do you engage in physical activity? Yes No

If yes, what activity? _____ How often?_____

Do you smoke cigarettes (cigars, chew)? Yes No #_____per day

How much alcohol do you drink? #_____per day _____# per week

Do you drink caffeinated beverages? Yes No If yes, how many per day?_____

Do you use illicit drugs? Yes No

If yes, how often and what drugs do you use?_____

Have you ever tried to cut down or stop using alcohol or drugs? Yes No

Has anyone ever asked you to cut down on your drinking? Yes No

Have you ever been hospitalized for any emotional/ mental health condition? Yes No

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Have you experienced or witnessed a traumatic event? (*parental violence, domestic violence, community violence, natural disaster, injury or death to a loved one*, etc)	Yes No
Do you have a history of domestic violence?	Yes No
Do you have a history of verbal, emotional or physical abuse?	Yes No
Do you have a history of sexual abuse or sexual assault?	Yes No

SUPPORT SYSTEMS

Do you have one or two friends that you consider close and feel you can depend on?	Yes No	
Do have a religion or spiritual practice that you experience as supportive?	Yes No	
Do you belong to any social groups or participate in hobbies with people that you enjoy?	Yes No	
Is there a family member that you trust and can go to in times of emotional need?	Yes No	
Are there other people or aspects of your life that you consider supportive?	Yes No	

FAMILY HISTORY

Have you or anyone in your family, experienced any of the following? If yes, please note their relationship to you. Please include extended family such as grandparents, uncles/aunts, siblings, and so on.

Has anyone experienced:	**Family Member (s):**
Anxiety	
Depression	
Bipolar disorder	
Learning disorders (ADHD, dyslexia, etc).	
Illicit drug use	
Alcohol abuse	
Schizophrenia	
Anger	
Eating Disorder	

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Phobias	
Hospitalization for Mental Health Condition	
Attempted or completed suicide	

Please circle any of the following areas that you would like to address in therapy:	
Family	Career/education
Parenting	Phase of life
Children	Stress
Relationships	Assertiveness
Alcohol or Drug use	Health Problems
Verbal abuse	Childhood experiences
Physical abuse	Loss or death
Emotional abuse	Spirituality
Sexual abuse	Self-esteem
Finances	Legal issues

Is there anything else that you would like me to know? _____
_____
_____