It's Your Journey Mental Health/Consulting Services, PLLC

Intake Form

Client Demographics: Date: _____

Name (First, Middle, Last Name): _____ DOB: _____ Age: _____

Address _____ City _____ Zip code _____

Phone (Primary) _____ Email (primary) _____

Emergency Contact Name: _____ Relation: _____ Phone: _____

Emergency Contact Name: _____ Relation: _____ Phone: _____

Tentative Times Available for Sessions:

Monday: AM ☐ PM ☐ Tuesday: AM ☐ PM ☐ Wednesday: AM ☐ PM ☐ Thursday: AM ☐ PM ☐

Friday: AM ☐ PM ☐ Saturday: AM ☐ PM ☐ Sunday: AM ☐ PM ☐

Personal Dynamics:

Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other _____

Straight (Cisgender) ☐ Bisexual ☐ Gay ☐ Lesbian ☐ Pansexual ☐ Transgender ☐ Queer ☐ Gender Fluid ☐

Prefer Not to Say ☐ Will Discuss in Session ☐ Asexual ☐ Questioning ☐ Sexual Active ☐ Not Sexually Active ☐

Current Living Support Systems (Relationship with family)

Live Alone ☐ Do you have pets? No if Yes what kind and what are their names _____

Live with Family ☐ (relation) _____ Homeless ☐ Live With Friends ☐ Other: _____

Feedback on therapy experiences and/or expectations.

Have you ever been in therapy before? Yes If "Yes" how long were you receiving therapeutic services (months, years etc.) _____

If you have been in therapy before, **what did you like** about your previous therapist and your sessions with them?

If you have been in therapy before**, what did you not like** about your previous therapist and your sessions with them?

What would a **good therapeutic session** look like for you?

What would a **bad therapeutic session** look like for you?

What do you want to work on in your therapy sessions?

What would your last therapy session look like for you? (thoughts, feelings etc.)

How did you find out about It's Your Journey Mental Health/Consulting Services, PLLC? _____