Lauren Johnson, LMFT
Living Water
2670 Memorial Blvd. B *Murfreesboro, TN 37129
615.390.3713 * lauren@livingwatermft.com

www.livingwatermft.com

Before you begin:

The following documentation has been prepared to educate you in order to make informed decisions about the therapeutic process.

1) **Please print and complete Intake Form**
2) Read: the Statement of Policies and Procedures
3) Read: Your Rights & HIPPA Regulations
4) **Print & sign the Consent to Treatment/Authorization Form**
5) **Bring with you the printed & completed forms above**
6) Due to the confidentiality nature of therapy, I ask that you respect the privacy of clients scheduled before you.

Please wait in the reception area. I will greet you there for your appointment.

Should you have any questions, please ask. You may want to make a list and bring them to the first session. If you have a question that needs to be answered before scheduling, please do not hesitate to contact me via phone or email.

I sincerely look forward to meeting you,

Lauren

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PRINT

INTAKE FORM

Name: _____ **Today's Date** _____

Age: _____ **Date of Birth:** _____
Address: _____

_____**(City)**_____ **(Zip)**_____

Telephone Number: *** ELECTRONIC MESSAGING IS NOT 100% SAFE**
(H) _____ May I leave a message? Yes ☐ No☐
(W) _____ May I leave a message? Yes ☐ No☐
(M) _____ May I leave a message? Yes ☐ No☐ Text: Yes ☐ No☐

Email_____
May I email you at this address?*** ELECTRONIC MESSAGING IS NOT 100% SAFE** Yes ☐ No☐

Occupation: _____

Marital Status: ☐Single ☐Engaged ☐Married ☐Cohabitating ☐Separated ☐Divorced ☐Widowed

*Engaged/Married:**Wedding Date:**_____**Spouse's name:**_____**Age:**___**Birthday**_____

Who lives in your home with you?
Example: Name /relationship son /age 14 Date of Birth: 02/14/1997
_____ /relationship _____ /age _____ Date of Birth: _____
_____ /relationship _____ /age _____ Date of Birth: _____
_____ /relationship _____ /age _____ Date of Birth: _____
_____ /relationship _____ /age _____ Date of Birth: _____
_____ /relationship _____ /age _____ Date of Birth: _____
_____ /relationship _____ /age _____ Date of Birth: _____

Children not living at home:
_____ /relationship _____ /age _____ Date of Birth: _____
_____ /relationship _____ /age _____ Date of Birth: _____
_____ /relationship _____ /age _____ Date of Birth: _____
_____ /relationship _____ /age _____ Date of Birth: _____
_____ /relationship _____ /age _____ Date of Birth: _____

Emergency Contact Information:
(Name) _____ /(Phone) _____
(Name) _____ /(Phone) _____

Religious Affiliation: _____

How did you hear about me? _____

Referred by: _____May I thank them for the referral? Yes ☐ No ☐

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PRINT

Have you been in counseling previously? Yes ☐ No ☐
(If yes, please list dates, focus of the sessions and reason counseling was terminated)

_____

CURRENT CHALLENGES THAT YOU ARE HAVING:

Please use a checkmark to indicate which of the following challenges apply to you.

☐ Depression
☐ Suicidal thoughts
☐ Suicidal actions
☐ Anxiety/Fears/Worries
☐ Anger temper problems
☐ Alcohol/other drug abuse (self)
☐ Alcohol/other drug abuse (family)
☐ Job/school problems/ unemployed
☐ Physical abuse when younger
☐ Death of a loved one
☐ Major losses/difficult changes
☐ Violence in the family (actual or threatened)
☐ Parent-child conflict
☐ Marital /relationship problems
☐ Brother/sister problems
☐ Financial concerns
☐ Communication problems
☐ Sexual problem
☐ Sexual abuse when younger
☐ Legal problems
☐ Problem Solving
☐ Eating Disorder

CHALLENGES WITH DAILY COPING?

Please use a checkmark to indicate which of the following challenges apply to you.

☐ Sleep problems
☐ Difficulty falling asleep
☐ Waking up in middle of the night
☐ Waking up too early
☐ Sleeping too much
☐ Nightmares
☐ Moody or crying more than usual
☐ Feeling guilty, worthless, or hopeless
☐ Fatigue/low energy
☐ Hyper/too much energy
☐ Loss of interest in things
☐ People are out to get me
☐ People are picking on me
☐ Change in appetite
☐ Gaining weight
☐ Losing weight
☐ Not hungry
☐ Vomiting after eating
☐ Nauseated
☐ Constipation or diarrhea
☐ Difficulties concentrating
☐ Problems remembering things
☐ Withdrawing from others
☐ Repeated actions that I can't stop
☐ Disturbing thoughts I can't stop
☐ Cannot stop washing hands, body, counting/checking things

☐ **Please specify: What brings you in today?**

_____
_____
_____
_____

Treatment of Minor Child

Parent or Legal Guardian Name _____
I give consent for treatment _____ (signature)
Child Name_____
Age _____/Grade _____

Person responsible for fees: _____ (PRINT)
Person responsible for fees: _____(signature)