



JP Family Therapy – Client Intake Form

Jocelyn Pijpaert, Ph.D., LMFT #87678
580 Broadway St. Suite 204, Laguna Beach, CA 92651
120 Vantis Dr. Suite 300, Aliso Viejo, CA 92656

Emergency Instructions: If you are in crisis, call 911 or go to your nearest emergency room.

1. Client Information

Full Legal Name: _____
Preferred Name / Pronouns: _____
Date of Birth: _____ Age: _____
Gender Identity: _____
Relationship Status: Single ☐ Married ☐ Domestic Partnership ☐ Separated ☐ Divorced ☐ Widowed ☐
Other: _____
Address: _____
City / State / Zip: _____
Phone (Cell): _____ OK to leave message? Y ☐ / N ☐
Phone (Home): _____ OK to leave message? Y ☐ / N ☐
Email: _____ OK to email? Y ☐ / N ☐
Preferred Method of Contact: Phone ☐ Email ☐ Text ☐

2. Emergency Contact

Name: _____
Relationship: _____
Phone: _____

3. Insurance & Payment Information (if applicable)

Insurance Provider: _____
Policy # / Member ID: _____
Group #: _____
Primary Insured Name & DOB: _____
Relationship to Client: _____

4. Presenting Concerns

Please briefly describe the reason(s) you are seeking therapy:

When did the problem(s) begin? _____

How distressing are these concerns? Mild ☐ Moderate ☐ Severe ☐

5. Mental Health History

Have you received therapy or counseling before? Yes ☐ No ☐
If yes, when and with whom? _____
Reason for previous therapy: _____
Was it helpful? Yes ☐ No ☐ Somewhat ☐
Have you ever been hospitalized for psychiatric reasons? Yes ☐ No ☐

If yes, please explain: _____

Given a mental health diagnosis? Yes ☐ No ☐ If yes, please list: _____

Suicidal thoughts or attempts (current or past)? Yes ☐ No ☐

Self-harming behaviors (current or past)? Yes ☐ No ☐

6. Medical History

Primary Care Physician: _____

Date of last physical exam: _____

Current medical conditions: _____

Current medications (including dosage & purpose): _____

Allergies: _____

7. Substance Use

Alcohol: Never ☐ Past ☐ Current ☐

Cannabis: Never ☐ Past ☐ Current ☐

Prescription misuse: Never ☐ Past ☐ Current ☐

Other substances: _____

If current, how often and how much? _____

8. Family & Social History

Who currently lives in your household? _____

Significant relationships (spouse/partner, children, close friends):

Any history of abuse (physical, emotional, sexual) you wish to share?

9. Cultural & Identity Factors (optional)

Ethnic/Cultural Background: _____

Religious/Spiritual Affiliation: _____

Sexual Orientation: _____

10. Goals for Therapy

What are your main goals or changes you hope to achieve?

11. Consent for Communication

Please check all that you consent to for communication:

Phone (Cell) ☐ Phone (Home) ☐ Email ☐ Text Messaging ☐ Voicemail messages ☐

Signature: _____ Date: _____