

## Adult Initial Intake Form

Please save this form in your computer (right-click and select "save as"), complete, save it and send it back to TELL Counseling. We provide the option to send it back as an e-mail attachment to [clinical.assist@telljp.com](mailto:clinical.assist@telljp.com). However, be advised that we cannot guarantee the confidentiality of your information due to the insecure nature of the Internet form of communication. If you have any doubts about submitting this form online, please print it out after completion and bring it with you to your first session. You can also send it back by fax to: 03-3797-3665 (Attention: Clinical Coordinator).

If you have any questions, please contact TELL Counseling at 03-4550-1146 (Monday-Friday, 10 am-5:30 pm). Thank you for your cooperation.

Today's date: \_\_\_\_\_ Type of counseling you are seeking:  Individual  Couples  Family

Appointment availability: \_\_\_\_\_

### Personal Information

Full Name: \_\_\_\_\_  M  F

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Nationality(s): \_\_\_\_\_

Preferred language for session: \_\_\_\_\_  
(For language other than English/Japanese, please consult first)

Marital Status: \_\_\_\_\_

E-mail: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Postal code: \_\_\_\_\_

Home phone no: \_\_\_\_\_

Cell phone no: \_\_\_\_\_

SKYPE ID: \_\_\_\_\_

### Emergency Contact in Japan (REQUIRED):

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone no.: \_\_\_\_\_

### If Client is a Minor:

Name of Responsible Adult: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone no.: \_\_\_\_\_

### Referral Source

How did you get to know about TELL?

- School/University  Friends/Family  
 Physician/Hospital  Clergy/Church  
 Legal/Government  Company /EAP  
 Media/ads  Other therapist  
 Internet Search Engine: \_\_\_\_\_  
 Other: \_\_\_\_\_

Who referred you to TELL Counseling?

- Yourself  School/University  
 Friends/Family  Lifeline  
 Other therapist  Physician/Hospital  
 Company /EAP  Health Insurance Company  
 Other: \_\_\_\_\_

Do you allow TELL to put you on the mailing list for activities/lectures provided by TELL?  Yes  No

### Living in Japan

- What private health insurance coverage do you have?  CIGNA International\*  Tricare\*  
 HTH / GeoBlue\*  No insurance  
 Other: \_\_\_\_\_  
 Company EAP\*: \_\_\_\_\_

\*Please contact your insurance/EAP company directly to obtain the following information about your coverage:

- My plan is \_\_\_\_\_, under the policy name of \_\_\_\_\_  
 My plan has a deductible of: ¥ \_\_\_\_\_ I have met ¥ \_\_\_\_\_ as of today.  
 I agree to pay full fee until my deductible is met and then I will pay my full co-pay at each session. If there is no deductible I will pay my full co-payment.  
 My plan pays \_\_\_\_\_% of the full fee, or ¥ \_\_\_\_\_. My co-pay is \_\_\_\_\_% of the full fee, or ¥ \_\_\_\_\_

- My plan has a yearly limitation of ¥ \_\_\_\_\_ and/or no. of visits \_\_\_\_\_
- My plan requires pre-approval of sessions or it will not reimburse.
- I agree to pay full fee if my plan does not pay TELL Counseling.
- My plan is an EAP and provides brief treatment. If I need more lengthy therapy, I understand that I may be self-referred or have to be referred out.
- Other \_\_\_\_\_
- Date (month and year) you or your family arrived in Japan (if applicable): \_\_\_\_\_
- What do you consider your home country?  
 Don't know / \_\_\_\_\_
- In how many countries have you lived? (including Japan): \_\_\_\_\_

- Status:  Japanese returnee  
 Foreign assignment  Diplomatic  
 Long-term/permanent resident  
 Other: \_\_\_\_\_
- How long do you estimate you will stay in Japan (in years)?  <1  1-2  3-5  
 >6  Undecided

- What are your most likely future plans in terms where to live?  Continue living in Japan  
 Live temporarily in a different country  
 Back to home country  
 Other: \_\_\_\_\_

**Present Status**

Why did you seek treatment at this time?

What are your goals in treatment?

**Past Treatment History**

- Are you currently receiving or have you previously received counseling / mental health services?  No  
 Yes, name of practitioner and type of services you are receiving: \_\_\_\_\_
- Have you ever been hospitalized for mental health concerns (incl. behavioral or emotional problems)?  No  
 Yes, list date(s) and length of stay: \_\_\_\_\_
- Have you ever been diagnosed with a psychological disorder?  No  
 Yes, list illness(es) and date (s) first diagnosed: \_\_\_\_\_
- Has anyone in your family ever been diagnosed with a psychological disorder?  No  
 Yes, list relationship(s) and illness(es): \_\_\_\_\_

**Vocational Background**

- Highest level of education:  
 Elementary school  Junior/High school  
 Professional degree  Bachelor's  Master's  
 PhD  Other: \_\_\_\_\_
- Currently working as: \_\_\_\_\_  
 Fulltime  Part-time  Unemployed  
 Homemaker  Retired  Student (fulltime)  
Name of employer/school: \_\_\_\_\_
- What is your usual occupation in your home country?  
\_\_\_\_\_
- List any special training, qualifications, or licensing:  
\_\_\_\_\_  
\_\_\_\_\_
- Please list past jobs, indicating both time and place (If space is insufficient, please add another sheet of paper).

**Employer/Place**

**Year**

Employer/Place	Year
_____	_____
_____	_____
_____	_____
_____	_____

**Legal Involvement**

- Have you had any legal/criminal problems?  
 No  Yes. Specify: \_\_\_\_\_
- Are you involved in a legal problem that is on trial /under discussion now (eg: divorce, child custody)?  
 No  Yes. Specify: \_\_\_\_\_
- Are you seeking disability and other benefits?  
 No  Yes