Ver.07.15

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. 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-6 pm). Thank you for your cooperation.

Today's date: _____ Appointment avail., day: _____ time: _____

Type of counseling: ☐ Individual ☐ Couple ☐ Family Location: ☐ Tokyo ☐ Yokohama ☐ TELL-etherapy

Personal Information

Full Name: _____ ☐ M ☐ F

Date of Birth: _____ Age: ___

Nationality(s): _____

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

Marital Status: -Select-

Address: _____

Postal code: _____

Home phone no: _____

Cell phone no: _____

E-mail:

SKYPE ID*:
*If required

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 ☐ Life Line
☐ 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* ☐ Not applicable
  ☐ 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

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. Please list name of practitioner and type of services you are receiving: _____
- *Have you ever been hospitalized for mental health concerns?* ☐ No
  ☐ Yes. Please, list date(s) and length of stay: _____
- *Have you ever been diagnosed with a psychological disorder?* ☐ No
  ☐ Yes. Please list illness(es) and date (s) first diagnosed: _____
- *Has anyone in your family ever been diagnosed with a psychological disorder?* ☐ No
  ☐ Yes. Please list relationship(s) and illness(es): _____
- *Have you ever been hospitalized for mental, behavioral or emotional problems?* ☐ No
  ☐ Yes. Please specify (when and where): _____

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/university: _____
- *What is your usual occupation in your home country?*
  _____
- *List any special training, qualifications, or licensing:*
  _____

Vocational History

Please list past jobs, indicating both time and place (If space is insufficient, please add another sheet of paper).

Employer	Time (Year)	Place (City)

Legal Involvement

- *Have you had any legal problems?*
  ☐ No
  ☐ Yes. Specify: _____
- *Are you seeking disability and other benefits?*
  ☐ No
  ☐ Yes. Specify: _____