**Adult Initial Intake Form**

Please complete the form, save it and send it back to TELL Counseling as an e-mail attachment to [intakesubmission@telljp.com](mailto:intakesubmission@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. If you have any questions, please contact TELL Counseling at [clinical.assist@telljp.com](mailto:clinical.assist@telljp.com).

**Today’s date:** **Edit** **Type of counseling:** Individual Couple Family Assessment

**Location:** Tokyo Yokohama  Distance Okinawa Kansai **Appointment avail., day of week: Edit** time: **Edit**

Personal Information

Full Name: **Edit** M F

Date of Birth: **Edit** Age: **Edit**

Nationality(s): **Edit**

Preferred language for session: **-Select-**

(For language other than English/Japanese, please consult first)

Marital Status: **-Select-**

Address: **Edit**

Postal code: **Edit**

Home phone no: **Edit**

Cell phone no: **Edit**

E-mail: **Edit**

SKYPE ID\*: **Edit**

\*If required

Emergency Contact in Japan (REQUIRED)

Name: **Edit**

Relationship: **Edit**

Phone no.: **Edit**

**If Client is a Minor:**

Name of Responsible Adult: **Edit**

Relationship: **Edit**

Phone no.: **Edit**

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: **Edit**

Other: **Edit**

Who referred you to TELL Counseling?

Yourself School/University

Friends/Family Life Line

Other therapist Physician/Hospital

Company /EAP Health Insurance Company

Other: **Edit**

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: **Edit**   
Company EAP\*: **Edit**

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

My plan is **Edit**, under the policy name of **Edit**

My plan has a deductible of: ¥**Edit** I have met ¥**Edit** 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 **Edit**% of the full fee, or ¥**Edit**. My co-pay is **Edit**% of the full fee, or ¥**Edit**

My plan has a yearly limitation of ¥**Edit** and/or no. of visits **Edit**

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 **Edit**

* Date (month and year) you or your family arrived in Japan (if applicable): **Edit**
* What do you consider your home country?

Don’t know / **Edit**

* In how many countries have you lived? (including Japan): **Edit**
* Status: Japanese returnee Foreign assignment Diplomatic Long-term/permanent resident Other: **Edit**
* 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: **Edit**

Present Status

*Why did you seek treatment at this time?*

**Edit**

*What are your goals in treatment?*

**Edit**

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

Vocational Background

* *Highest level of education:*

Elementary school Junior/High school

Professional degree Bachelor's

Master's PhD

Other: **Edit**

* *Currently working as:* **Edit**

Fulltime Part-time

Unemployed Homemaker

Retired Student (fulltime)

*Name of employer/university:* **Edit**

* *What is your usual occupation in your home country?*

**Edit**

* *List any special training, qualifications, or licensing:***Edit**

**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)**

|  |  |  |
| --- | --- | --- |
| **Edit** | **Edit** | **Edit** |
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Legal Involvement

* *Have you had any legal problems?*

No Yes. Specify: **Edit**

* *Are you seeking disability and other benefits?*No

Yes. Specify:  **Edit**

\*\*Thank you for your cooperation\*\*