Sankofa Sex Therapy, LLC
De-Andrea Blaylock-Johnson, MSW, LCSW
10176 Corporate Square Drive, Suite 100-S
St. Louis, MO 63132
314-877-8510 Phone
SankofaSexTherapy@gmail.com
SankofaSexTherapy.com

Intake Forms

Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential information.
Please fill out this form and bring it to your first session.

Name: ____
(Last) (First) (Middle Initial)
Name of parent/guardian (if under 18 years):

____
(Last) (First) (Middle Initial)

Birth Date: ____ /____ /____ Age: _____ Gender: □ Female □ Male □ Trans □ Intersex □ Other _____
Marital Status:
□ Never Married □ Partnership □ Married □ Separated
□ Divorced □ Widowed
Please list any children/ages:

____

____

Address:

____
(Street and Number)

____
(City) (State) (Zip)

Home Phone: _________________________ May we leave a message? □Yes □No

Cell: ________________________________ May we leave a message? □Yes □No

Work Phone: __________________________ May we leave a message? □Yes □No

E-mail: _______________________________________ May we email you? □Yes □No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): ____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner: ____
Are you currently taking any prescription medication?
□ Yes □ No
Please list:
____

____

Have you ever been prescribed psychiatric medication?
□ Yes □ No
Please list and provide dates:

____

____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION
1. How would you rate your current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific health problems you are currently experiencing:

____

2. How would you rate your current sleeping habits? (Please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific sleep problems you are currently experiencing:

____

3. How many times per week do you generally exercise? __________

What types of exercise to you participate in: _________________________________
4. Please list any difficulties you experience with your appetite or eating patterns.

____

____

5. Are you currently experiencing overwhelming sadness, grief or depression?
□ No □ Yes
If yes, for approximately how long? ________________________
6. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No □ Yes
If yes, when did you begin experiencing this? ___________________________

7. Are you currently experiencing any chronic pain?
□ No □ Yes
If yes, please describe: ____________________________
8. Do you drink alcohol more than once a week? □ No □ Yes
If yes, please describe: ____________________________
9. How often do you engage recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never
10. Are you currently in a romantic relationship? □ No □ Yes
If yes, for how long? __________________
On a scale of 1-10, how would you rate your relationship? __________
11. What significant life changes or stressful events have you experienced recently:
____

____

FAMILY MENTAL HEALTH HISTORY:
In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).
Please Circle and list family member

Alcohol/Substance Abuse	yes/no	____________________________
Anxiety	yes/no	____________________________
Depression	yes/no	____________________________
Domestic Violence	yes/no	____________________________
Eating Disorders	yes/no	____________________________
Obesity	yes/no	____________________________
Obsessive Compulsive Behavior	yes/no	____________________________
Schizophrenia	yes/no	____________________________
Suicide Attempts or Thoughts	yes/no	____________________________
Self-injurious Behaviors	yes/no	____________________________

ADDITIONAL INFORMATION:
1. Are you currently employed? □ No □ Yes
If yes, name and address of your employer:

____

____
Do you enjoy your work? Is there anything stressful about your current work?

____

____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief:

____

3. What do you consider to be some of your strengths?

___

___

___

4. What do you consider to be some of your weakness?

___

___

___

5. What would you like to accomplish out of your time in therapy?

___

___

___

CREDIT CARD AUTHORIZATION FORM

Please note that this form will be securely stored in your clinical file and you are willing to assume the risk for keeping this information on file.

I authorize De-Andrea Blaylock-Johnson, Licensed Clinical Social Worker #2010006307 at Sankofa Sex Therapy, LLC to keep my signature and card information on file and to charge for unpaid therapy session fees (individual, couple, family, group, consultation or other), to charge for insurance co-pays and/or payments not covered by insurance, or for any appointments with De-Andrea Blaylock-Johnson, MSW, LCSW that are not cancelled within 24 hours of the scheduled appointment time. I understand that this form is valid until cancelled in writing or within 90 days of termination of services. I understand that I will be charged for missed appointments within 72 hours of the missed session. Additionally, I agree that the card listed will be charged within one week upon termination of services for any outstanding balances accrued by the client.

I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact De-Andrea Blaylock-Johnson, MSW, LCSW for assistance and/or disclosure. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with De-Andrea Blaylock-Johnson, MSW, LCSW and those attempts have failed.

I understand and agree to these terms. I understand the conditions of this payment policy and agree to the conditions stated above:

Cardholder Name (Print): ____

Zip Code: ____

Card Type (Visa, MasterCard): ____________________________________

Credit Card Number: ____

Expiration Date: _________________________ Security Code: __________

Signature: ____________________________________ Date: ____________

PHYSICIAN NOTICE AND RELEASE OF INFORMATION

Most insurance plans request that the therapist notify the physician that their patient is being seen in counseling. Please complete and sign. If you do not wish for your physician to have this notice in your medical files, please indicate below.

____
Name of MD

____
Address of MD

____
City, State and zip of MD

The client named below is receiving psychotherapy at this office with De-Andrea Blaylock-Johnson, LCSW. The client has indicated that you are the primary physician _____ or psychiatrist_____.

The client's insurance has requested that you be notified, and the client has authorized this notice. I look forward to working with you in a team effort for the benefit of the client.

If you wish to contact me, please call (314) 877-8510.

Thank you.

De-Andrea Blaylock-Johnson, MSW, LCSW

I________________________ authorize _______ (do not authorize _______) that this
Print Your Name

notice be sent to the above named doctor and further authorize consultations between the patient's doctor and therapist relative to my medical and psychological care.

____ Date: ___________
Signature of patient or guardian of minor

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MEDICAL HISTORY

Please complete this form as this information is very important. Please feel free to add any additional information that you feel is needed.

Name: ____

Current Physician and/or Primary Care Physician: ____________________________________

Address: _____________________________City/State: _______________ Zip: _______________

Phone: _______________________________

Medications prescribed by this M.D. (Name and dosage)_________________________________
____
____

Are you are under the care of a psychiatrist? Yes______ No______

Name of Psychiatrist or Psychiatric Nurse
____

Address: _____________________________City/State: _______________ Zip: _______________

Medication and dosage prescribed by Psychiatrist: ___________________________________
____

Have you been hospitalized for emotional problems? Yes_________ No__________________

If so: When____________________Where_______________________________________

Have you had previous individual therapy? Yes____No_____ Dates:_______

Name of Therapist:__________________________Address:___________________________

City:_______________Zip___________Telephone____________________________________

Name of Therapist:__________________________Address:___________________________

City:_______________Zip___________Telephone__________________________

Have you been treated for substance abuse? No: _____ Yes: _____ Date: _____________

Are you being treated now for substance abuse? No: _____ Yes: _____

Please list any and all physical illnesses that are now being treated by a physician:

____
____
____
____

What would you want your therapist to know about your physical or emotional health:
____
____
____

I authorize De-Andrea Blaylock-Johnson, LCSW to contact by telephone or mail the following medical professionals for the purpose of consulting and coordinating care for my therapy and treatment.

Name______________________________Address:_____________________________

City: _________________ State: _____________ Zip: ___________________________

Phone: (   )___________________________Fax: (   )__________________________

Name______________________________Address:_____________________________

City: _________________ State: _____________ Zip: ___________________________

Phone: (   )___________________________Fax: (   )__________________________

_______________________________________ Date: _____________________________
Signature