

Joslyn Cruz, Ph.D.

Licensed Psychologist



Client Welcome & Intake Form

Adult (18+)

Please complete as fully as possible. If a question does not apply or you'd prefer to discuss it in session, write "discuss."

CLIENT INFORMATION

Full Name Preferred Name Pronouns

Date of Birth Age Occupation / Field Employer (optional)

Street Address City State Zip

Phone Email Preferred Contact Method

Contact preferences: OK to leave voicemail OK to text OK to email

Emergency Contact Name Relationship Phone

REASON FOR REFERRAL

What brings you to therapy at this time?

How long have these concerns been present?

What are your goals for therapy?

PRIMARY CONCERNS

Please check all that apply:

- Anxiety / worry
- Depression / low mood
- Stress / burnout
- Relationship difficulties
- Infidelity / betrayal
- Sexual behavior concerns
- Pornography use concerns
- Identity / self-esteem
- Life transitions
- Trauma / PTSD
- Grief / loss
- Anger / irritability
- Substance use concerns
- Sleep difficulties
- Difficulty with focus / attention
- Other (describe below)

Other concerns

CURRENT FUNCTIONING

Describe your current living situation (who you live with, relationship status, etc.):

Describe your current work or school situation:

How would you rate your overall daily functioning?

- Managing well
- Struggling somewhat
- Significantly impaired

RELATIONSHIPS & SOCIAL HISTORY

Current relationship status	Length of relationship (if applicable)	Children? (ages)

Briefly describe your current significant relationships (partner, family, close friends):

Any significant relationship history relevant to your current concerns?

MEDICAL HISTORY & CURRENT PROVIDERS

Primary Care Provider Name	Phone
Psychiatrist / Prescriber (if any)	Phone

Current Medications (name, dose, frequency)

[Redacted area for Current Medications]

Known allergies

[Redacted area for Known allergies]

Significant medical conditions

[Redacted area for Significant medical conditions]

I authorize Dr. Cruz to coordinate care with the providers listed above (Release of Information).

BEHAVIORAL & EMOTIONAL HEALTH

Please indicate any current concerns:

- Difficulty managing emotions
- Anxiety or excessive worry
- Impulsive behaviors
- Perfectionism / self-criticism
- Frequent anger or outbursts
- Low mood or loss of interest
- Risk-taking behaviors
- Difficulty with focus / attention

Sexual behavior (please indicate if relevant — all information is confidential):

- Excessive pornography use
- Compulsive sexual behavior
- Paraphilic interests causing distress
- Secretive online behavior
- Infidelity / betrayal concerns
- Prefer to discuss in session

Other (optional)

[Redacted area for Other (optional)]

SAFETY & RISK

Have you ever:

- Talked about or had thoughts of wanting to die or not be here
- Engaged in self-injury
- Made a suicide attempt
- Harmed or had urges to harm others

If yes, please describe (timing, frequency, current status):

[Redacted area for description of safety and risk]

SUBSTANCE USE SCREENING

Current or recent use:

- Alcohol
- Nicotine / vaping
- Other substances
- Cannabis / THC
- Prescription misuse
- None

Details (frequency, context, concerns)

[Redacted area for substance use screening details]

DIAGNOSTIC & TREATMENT HISTORY

Previously diagnosed with:

- | | |
|---|---|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Autism Spectrum Disorder |
| <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> Depressive disorder |
| <input type="checkbox"/> Learning disability / LD | <input type="checkbox"/> Trauma-related |
| <input type="checkbox"/> None | <input type="checkbox"/> Other |

Relevant history (trauma, significant life events, developmental notes, etc.):

FAMILY MENTAL HEALTH HISTORY

Any history of mental health conditions, substance use, or suicide in biological relatives?

PREVIOUS TREATMENT

Have you previously received therapy, counseling, or psychiatric care? What was helpful or not helpful?

CLIENT PERSPECTIVE

What do you feel you need most right now?

What would improvement look like in 3–6 months?

What strategies or approaches have you already tried?

FINANCIAL INFORMATION (PRIVATE-PAY PRACTICE)

This is a private-pay practice. The fee is **\$250 per 50-minute session**, due at the time of service. Upon request, Dr. Cruz will provide a monthly superbill for possible out-of-network reimbursement; reimbursement is not guaranteed.

Accepted forms of payment: cash, check, credit card, HSA, FSA, and Zelle.

Name on Card / Account Holder	Preferred Payment Method
<input type="text"/>	<input type="text"/>

CANCELLATION POLICY

Sessions cancelled with less than **24 hours' notice**, or missed without notice, are charged the full session fee.

I have read and agree to the cancellation policy above.

TELEHEALTH CONSENT

Dr. Cruz offers telehealth sessions to clients physically located in Connecticut, New York, or Michigan at the time of session. The client agrees to participate from a private, quiet location and to confirm their physical address at the start of each telehealth session. Technology limitations, privacy risks, and the possibility of switching to in-person or phone sessions have been explained. In a safety emergency, Dr. Cruz may contact local emergency services.

I consent to receive telehealth services under the conditions described above.

SIGNATURES

Client Printed Name	Date
<input type="text"/>	<input type="text"/>

Client Signature

Clinician Signature — Joslyn Cruz, Ph.D.	Date
<input type="text"/>	<input type="text"/>