Background Information

12 SE 14th Ave, Suite 203, Portland, OR, 97214

Today's Date:_____

Name(s)_____Referral Source_____

Address_____

Phone_____Email_____
(Ok to leave message? Yes/No)

Date(s) of Birth_____Occupation_____

Highest Level of Education_____Total House Income_____

Place of Employment_____City_____

Relationship Status:

___Single ___Married ___Divorced ___Separated ___Widowed ___Cohabitating

How long? _____

Please list the name, sex, age, and relationship of those living in your home besides yourself. This can include your spouse, children, partner, friend, or anyone else living with you.

Name & Relationship **Sex** **Age**

Reason(s) for seeking counseling now:

Please describe why you have chosen to seek out counseling at this point.

How long has this issue been a part of your life? When did it begin?

What are your goals for counseling?

Medical History

Primary Physician_____ Date of last visit_____

Current medical conditions:

Current medications	Dosage/Frequency	Reason for Taking

Please list any surgeries, accidents, or injuries you have experienced, including dates:

Do you or anyone in your immediate family struggle with any form of addiction? (Can include, but is not limited to, alcohol, substance, gambling, sexual activities)

Do you use alcohol, drugs, nicotine, or caffeine regularly? If so, how much/often?

Personal History

Where were you born? Where did you grow up?

How many brothers do you have? Sisters? Where are you in birth order?

What was the level of closeness in your family growing up?

Did you ever feel unsafe? Why?

Were there any deaths in your family? How did they affect you?

Please note any divorces in your family while growing up, including your age at the time.

What was your childhood like?

Please check any of the following that describes your family and home atmosphere as a child:

❒ Alcoholism
❒ Affectionate
❒ Angry
❒ Binging/Purging
❒ Body Image Issues
❒ Close
❒ Cold
❒ Competitive
❒ Democratic
❒ Distant
❒ Emotional Abuse
❒ Extreme Dieting
❒ Fighting
❒ Frightening
❒ Mental Illness
❒ Moving Excessively
❒ Neglectful
❒ Overprotective
❒ Parental Divorce
❒ Physical Abuse
❒ Physical Illness
❒ Poverty
❒ Rigid
❒ Safe
❒ Sexual Abuse
❒ Stable
❒ Supportive
❒ Trusting
❒ Weight Issues
❒ Known family history of physical or sexual abuse: _____
❒ Anything else you think might be important for me to know while we're working together?

_____

Overall you would describe your family life growing up as:

❒ Affirming ❒ Chaotic ❒ Confusing ❒ Hostile ❒ Loving
❒ Negative ❒ Safe ❒ Strict ❒ Supportive ❒ Unsafe

Marriage History

Are you married? _____ If so, what number marriage is this? _____

Is your marriage an area of struggle or of strength for you?

Social History

Are you satisfied with your current social life? Please briefly explain.

Describe your relationship with your closest friend(s) and how often you get together.

Spiritual History

What spiritual tradition, if any, were you raised in? Do you still hold those same beliefs? If not, how have they changed?

Have you found your spiritual beliefs to be helpful or a hindrance? Why?

Mental Health History

Have you ever been involved in counseling before? If so, when?

What was the reason for counseling previously?

Do you consider the experience to have been successful? Why or why not?

What did you like and dislike about your previous experience in therapy?

Is there anything you wished you have had more or less of during that time?

Have you or any of your immediate family members ever seriously considered or attempted suicide?

Do you have any concerns about the counseling process? Please explain.

Please indicate all that you believe apply to you:

❒ Threats of killing or hurting self
❒ Threats of killing someone else
❒ Hear or see things others do not
❒ Exposure to traumatic event
❒ Avoidance of responsibility
❒ Over-tired or easily fatigued
❒ Unable to keep friends
❒ Pre-occupation with sex
❒ Frequent physical complaints
❒ Exaggerated sense of worth
❒ Mood goes up and down a lot
❒ Sad most of the time
❒ Tics/other involuntary movements
❒ Not interested in things
❒ Hard to concentrate
❒ Prescription drug abuse
❒ Pornography
❒ Abortion
❒ Any kind of reference to killing or hurting self
❒ Any kind of reference to killing someone else
❒ Self injury
❒ Bed wetting
❒ Secretive
❒ Eating Problems
❒ Angry mood
❒ Nightmares
❒ Lots of energy
❒ Hopelessness
❒ Frequent conflict
❒ Fearful
❒ Delinquency
❒ Spiritual problem
❒ Weight problem
❒ Lack confidence
❒ Acting without thinking
❒ Recurring thoughts
❒ Difficulty sleeping
❒ Domestic Violence
❒ Internet relationship(s)
❒ Purging Food
❒ Dieting
❒ Hard to remember things
❒ Hair pulling
❒ Infidelity/Affair
❒ Body Image Issues
❒ Fire Setting
❒ Arrests
❒ Stealing
❒ Irritable mood
❒ Argumentative
❒ Racing thoughts
❒ Muscle Tension
❒ Worry a lot
❒ Vandalism
❒ Flash-backs
❒ Sexual difficulty
❒ Helplessness
❒ Hurting animals
❒ Tearful
❒ Lying
❒ Blames others
❒ Repetitive Behaviors
❒ Drug/alcohol abuse
❒ Poor decisions
❒ Extreme shyness

Mood Scale

Please indicate your general mood level for the last month by circling one of the numbers on the scale below:

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

Suicide ideas Depressed Average Good spirits Joyful

Anxiety Scale

Please circle one number on the 1 to 10 scale below to indicate your general level of anxiety or nervousness over the past month. The higher the number you indicate, the higher the level of distress you are reporting.

1 2 3 4 5 6 7 8 9 10

Peaceful Panicky

Physical History

Do you eat healthy, balanced meals regularly?

Do you exercise? What do you do and how often?

Do you or have you ever made yourself sick because you feel uncomfortably full? When?

Do you worry you have lost control over how much/little you eat? How so?

Have you recently lost a large amount of weight in a small amount of time?

Do you use the Internet to look at pornography? How often?

Educational History

What was the last grade in school (or degree) that you completed?

How did you do academically in school (grade, middle, high)?

Have you ever been tested for a learning disability? Yes _____ No _____

Military Experience

Have you ever been in the armed forces? Yes ____ No _____

If yes, what were the approximate dates of service? _____ to _____

Please describe your reasons for leaving the military and the type of discharge you received.

Describe your feelings about your military service or any special experiences that influenced you:

Personal Assessment

In your opinion, what are your three main strengths?

What do you believe are your top three growth areas?

How do you feel counseling can be helpful to you?

Please initial each statement:

I have received a copy of the Professional Disclosure Statement. _____
I understand that payment is due at the beginning of each session. _____
I understand I will be charged the full session fee for less than 24 hours notice. _____
Is there anything further you would like to explain or add to anything above?

_____

_____

I have done my best to answer these questions as honestly and completely as possible.

_____ _____
Client Signature Date