Discover Counseling

7320 SW Hunziker St., Suite 204 | Tigard, OR 97223
Phone: 971.217.8164 | Fax: 866.802.8062
Email: renee@discovercounseling.com

Confidential Client Intake Information

GENERAL INFORMATION

Full Name: _____ Name You Prefer: _____
Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female
Referred by: _____

CONTACT INFORMATION

Street Address: _____ Suite / Apt. #: _____
City: _____ State: _____ Zip: _____ OK to send mail here? ☐ Yes ☐ No
Home Phone: (_____)_____ OK to leave message here? ☐ Yes ☐ No
Cell Phone: (_____)_____ OK to leave message here? ☐ Yes ☐ No
Text Messaging: can we send text messages to your cell phone? ☐ Yes ☐ No
Email Address: _____ OK to send mail here? ☐ Yes ☐ No

EMERGENCY CONTACT

Name: _____ Relationship: _____
Home Phone: (_____)_____ Cell Phone: (_____)_____

EMPLOYMENT & EDUCATION INFORMATION

Employer: _____ Length of Employment: _____
Occupation: _____ Average Hours Worked Per Week: _____
Annual Household Income: _____ Highest Grade of Education: _____
Are You Currently In School? ☐ Yes ☐ No If Yes, What Level: _____ Degree Pursuing: _____

RELIGIOUS BACKGROUND

Do you consider yourself: ☐ Atheist ☐ Agnostic ☐ Religious/Spiritual ☐ Other: _____
How would you describe your religious/spiritual beliefs: _____
Do you regularly attend a place of worship? ☐ Yes ☐ No If yes, where? _____
Briefly describe the religious environment of the home you grew up in: _____
Complete the following thought: "God is _____"

RELATIONAL INFORMATION

Current Marital Status:

☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If Married, How Long? _____ # of Previous Marriages for You: _____ For Spouse: _____
If Separated or Divorced, How Long? _____ If Widowed, How Long? _____
Who Do You Currently Live With? (Check All That Apply)

☐ Alone ☐ Spouse ☐ Parent(s) ☐ Sibling(s)
☐ Boyfriend ☐ Girlfriend ☐ Child(ren) ☐ Other: _____

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PARTNER INFORMATION (if applicable)

Full Name: _____ How Long Have You Been Together? _____

Age: _____ Sex: ☐ Male ☐ Female Occupation: _____

CHILDREN

Please list your children (living or deceased) as well as any children you have placed for adoption:

Name	Sex	Current Age or Year of Death	Relationship To You (Natural, Step, Adopted)	Living With You?	1-2 Word Description:

Have you ever had a miscarriage or medical abortion? ☐ Yes ☐ No If yes, when? _____

Has your *partner* ever had a miscarriage or medical abortion? ☐ Yes ☐ No If yes, when? _____

FAMILY OF ORIGIN - SELF

Please list family members (immediate or extended family) who affected you positively or negatively:

Name	Relationship To You (Mom, Dad, Brother, Sister, Step, etc.)	Current Age or Year of Death	Occupation	2-4 Word Description:

Overall, your family life growing up was:

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

How did your family deal with conflict growing up:

☐ Yell or scream ☐ Physical aggression ☐ Talking/listening ☐ Ignoring *people*
☐ Ignoring *issues* ☐ Isolating (silent treatment) ☐ Safe ☐ Guilt or manipulation

FAMILY OF ORIGIN – PARTNER (if applicable)

Please list family members (immediate or extended family) who affected you positively or negatively:

Name	Relationship To You (Mom, Dad, Brother, Sister, Step, etc.)	Current Age or Year of Death	Occupation	2-4 Word Description:

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MEDICAL INFORMATION

Primary Care Physician: _____ Phone: (_____)_____

Address: _____ City: _____ Zip: _____

Are you currently receiving medical treatment? ☐ Yes ☐ No If yes, please specify: _____

Please list conditions, illnesses, surgeries, hospitalizations, traumas, or related treatments you've had:

_____

_____

MEDICATION INFORMATION

Please list all current medications you are taking, including those you seldom take or only as needed:

Medication	Dosage & Frequency	Improves, Prevents, or Controls (Symptoms)	Treating (Illness)

Are you taking these according to your doctor's recommendations? ☐ Yes ☐ No

If no, please briefly explain: _____

PHYSIOLOGICAL SYMPTOMS

Please check any of the following problems that apply to you (Self = X, Partner = O):

	X	O		X	O		X	O
Addiction			Impulsivity			Preoccupation with sex		
Anger			Infidelity or affair(s)			Prescription drug abuse		
Anxiety / Stress / Worry			Internet relationship(s)			Racing thoughts		
Appetite problems			Insomnia			Recurring thoughts		
Argumentative			Intrusive thoughts			Relationships		
Avoidance of responsibility			Irritability			Restlessness		
Blaming others			Joint/Muscle			Sadness or crying		
Cancer/Tumors			Lack of confidence			Secrets / hiding things		
Compulsions			Learning/Focus			Self-harm		
Concentration			Legal difficulties			Sexual abuse		
Depression			Loss of energy			Sexual difficulties		
Disordered eating			Memory			Sleeping problems		
Domestic violence			Medication issues			Social anxiety		
Emotional Abuse			Mood swings			Spiritual problem		
Employment			Nervousness			Stomach issues		

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Excessive guilt			Nightmares			Substance abuse		
Extreme shyness			Night sweats			Thoughts of death		
Fear of leaving home			Obsessions			Tiredness or fatigue		
Financial Concerns			Panic			Trauma		
Frequent conflicts			Paranoia			Trauma flashbacks		
Hearing/seeing things			Personality disorder			Unable to keep friends		
Headaches or Dizziness			Phobias			Veteran/Military		
Head Injury			Physical abuse			Weight change		
Hypersomnia			Poor decisions			Worthlessness		
Hypertension			Pornography use			Other:		

LIFE EXPERIENCES

Please check any of the following experiences you have had (Self = X, Partner = O):

	X	O		X	O		X	O
Adoption			Feeling numb			Natural disaster		
Avoiding unwanted thoughts			Feeling out of body			Not knowing where I am		
Bad memory			Feeling out of place			Parental divorce		
Basic needs not met			Frequently moving			Parental separation		
Been attacked			Head injury			Strong feelings of guilt		
Blacking out at times			Holes in my memory			Sudden life threatening illness		
Blank childhood memory			Hypervigilant			Thoughts causing nausea		
Crime victim			Known family history of physical/sexual abuse			Unusual thoughts or memories during sex		
Death in the family			Legal/court issues			Verbal, physical abuse		
Easily startled			Lived in combat area			Violence in home		
Feeling "checked out"			Living in constant fear			Waking up feeling lost		
Feeling "keyed up"			"Losing time" recently			Wondering who I am		

LEVEL OF DISTRESS

Indicate your level of distress on a 0-10 scale (0 = none; 10 = extreme): Self: _____ Partner: _____

Are you currently experiencing any suicidal thoughts? ☐ Yes ☐ No In the past? ☐ Yes ☐ No

Have you ever attempted suicide? ☐ Yes ☐ No If yes, when and how? _____

Have any family or friends ever attempted or committed suicide? ☐ Yes ☐ No

If yes, who and when? _____

PRESENTING ISSUES AND GOALS

Please describe why you are coming to counseling (e.g., What are your issues/problems?)

_____

_____

Why did you decide to come to counseling now? _____

_____

What do you hope to gain by coming to counseling? _____

_____

How long do you believe counseling will (or should) last?_____

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PREVIOUS COUNSELING

Please list any prior counseling, psychiatric treatment, or residential/inpatient care you have received:

Therapist: _____ Location: _____
Dates: _____ Reason: _____

Therapist: _____ Location: _____
Dates: _____ Reason: _____

Therapist: _____ Location: _____
Dates: _____ Reason: _____

Therapist: _____ Location: _____
Dates: _____ Reason: _____

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Dates: _____ Reason: _____

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Authorization to Release Protected Health Information (Optional)

Client Information	Name _____ Date of Birth _____ Address _____ City _____ State _____ Zip Code _____ Phone Number_____
Clinic/Health Care Provider Who has the information to be released?	Name _____ Address _____ City _____ State _____ Zip Code _____ Phone Number_____ Fax Number _____
Receiving Party Who will the information be released to?	Name _____ Relationship to Client _____ Address _____ City _____ State _____ Zip Code _____ Phone Number_____ Fax Number _____
Information to Be Released What will be released?	☐ Whether the client is in treatment or not ☐ Prognosis (diagnosis, opinion of how treatment will benefit client, general peculiarities of case) ☐ Brief statement regarding progress (client's denial, client's understanding of their condition, progress or lack of progress on goals, cooperation with treatment plan and rules) ☐ Brief statement regarding relapse and frequency of relapse (cannot identify specific drugs)
Purpose of Release Why is information being released?	☐ Referral to other services ☐ Coordination of care ☐ Consultation with Doctor ☐ Consultation with other mental health provider ☐ Transfer of care ☐ Other: _____

Signature of Client _____ **Date**_____

Signature of Clinician _____ Date_____

This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____. This authorization may be canceled in writing at any time. A photocopy/fax of this authorization will be treated in the same way as an original. Your signature indicates that you have read and understand this form, and authorize release of your information as described above. I understand that I may refuse to sign this authorization and that refusal to sign will not affect treatment. FOR THE RECIPIENT OF THE INFORMATION: If any of the requested records contain information regarding alcohol or drug abuse treatment, it may be protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the use or release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.