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CLIENT INTAKE FORM

Legal Name: ----- Male Female Other

Name you prefer: _____ Date of Birth: _____ Age: __ __

Mailing Address: _____ City: _____ Zip: _____

Home Phone: _____ Ok to leave message

Cell Phone: _____ Ok to leave message

Preferred method of contact: Phone call Text messaging email

Would you like email reminders of your appointment? Yes No Email address (if yes) _____

Would you like text reminders of your appointment? Yes No

Relationship status: Single Married Domestic Partnership Separated Divorced Widowed Other

How long with current partner? _____ Living together? Yes No

Children: Names and ages _____

Emergency contact: _____ Phone: _____ Relationship: _____

Referred by (please check all that apply): Good Therapy Psychology Today Portland Therapy Center

Online search directly led me to your website Word of mouth
(name of the person who referred you) _____

Other _____

Your answers to the questions below will provide additional information that will be beneficial to our counseling sessions. Please answer the questions below as completely as is comfortable for you. All answers will be kept confidential.

About counseling ...

Briefly describe the problem that brings you to counseling: _____

What have you done to try and resolve this problem? _____

After counseling, what do you hope will be different regarding this problem? _____

What previous experience do you have with counseling? _____

Please mark any of the following that you are currently experiencing:

- | | | |
|---|---|---|
| <input type="checkbox"/> Aggression/Fights | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Parenting Problems |
| <input type="checkbox"/> Anxiety/Worry | <input type="checkbox"/> Hearing voices | <input type="checkbox"/> Poor memory/Confusion |
| <input type="checkbox"/> Appetite Issues | <input type="checkbox"/> Hoarding | <input type="checkbox"/> Problems with Pornography |
| <input type="checkbox"/> Avoidance | <input type="checkbox"/> Homicidal Thoughts | <input type="checkbox"/> Racing Thoughts |
| <input type="checkbox"/> Compulsive Behavior | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Relationship Problems |
| <input type="checkbox"/> Computer Addiction | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Risky Activity |
| <input type="checkbox"/> Crying Spells | <input type="checkbox"/> Increasing alcohol/Drug Use | <input type="checkbox"/> Self-harm Behaviors |
| <input type="checkbox"/> Depression/Sadness | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Irritability/Anger | <input type="checkbox"/> Shopping Addiction |
| <input type="checkbox"/> Eating Problems | <input type="checkbox"/> Lack of Motivation | <input type="checkbox"/> Social discomfort |
| <input type="checkbox"/> Excessive Energy | <input type="checkbox"/> Libido Changes | <input type="checkbox"/> Sleep Changes/Problems |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Suspicion/Paranoia |
| <input type="checkbox"/> Fear Away from Home | <input type="checkbox"/> Loss of Pleasure/Interest | <input type="checkbox"/> Withdrawal from people |
| <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Low self worth | <input type="checkbox"/> Work/school problems |
| <input type="checkbox"/> Frequent Arguments | <input type="checkbox"/> Nightmares | |
| <input type="checkbox"/> Gambling Problems | <input type="checkbox"/> Obsessive thoughts | |
| <input type="checkbox"/> Guilt/Shame | <input type="checkbox"/> Panic attacks | |

Other: _____

Are you currently experiencing suicidal thoughts? No Yes If yes, please describe: _____

Have you experienced suicidal thoughts in the past? No Yes If yes, please explain: _____

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

If yes, please describe the attempt: _____

Are you or anyone in your household currently experiencing abuse or violence of any kind? No Yes

If yes, please explain: -----

Present Situation

How would you describe your current intimate relationship (if any): _____

Are you divorced? If yes, specify year of divorce: _____

Prior marriages? If yes, how **many**? -----

Do you have child(ren)? If yes, how is your relationship with your child(ren): _____

Briefly tell me about your network of social support (friends, co-workers, neighbors, religious/spiritual, self-help/support groups, etc.) _____

Do you feel you have an adequate support system? No Yes

Medical History

How would you describe your physical health? _____

Are you currently being treated for any medical conditions? Yes No Please explain _____

Are you currently taking any medication for mental health or medical condition? Yes No

Medication: _____ Dosage: _____ per/____ _

Medication: _____ Dosage: _____ per/____ _

Medication: _____ Dosage: _____ per/____ _

What was your previous mental health diagnosis (if applicable) _____

Have you ever tried the following? (check all that apply)

- Alcohol
- Cocaine**
- Ecstasy
- Hallucinogens**

- Heroin**
- Marijuana**
- Methadone
- Methamphetamines**

- Pain Killers**
- Stimulants**
- Tobacco**
- Tranquilizers**

Other _____

If yes to any, list frequency and dates of last use: -----

Have you ever been treated for drug/alcohol abuse? If yes, when? _____

Have you ever abused prescription drugs? If yes, which ones? _____

Family history..... In a few words, describe what your relationship has been like with your:

Mother: _____

Father: _____

Siblings (include ages): _____

Other significant family members: -----

Before you were 18, did you experience any of the following?:

Parents divorced (your age ___ }

Lived with step-parent or step-siblings

Adopted (your age ___ }

Raised by someone other than parent (Who? _____

Other _____

Have you experienced the death of someone close to you? Please give the name and relationship of the person(s) and when they died (or your age at the time): _____

Did either of your parents abuse alcohol or other drugs? _____

Were the adults in your household abusive or disrespectful to each other? _____

Were you verbally, emotionally, sexually or physically abused? _____

Do any of your current or extended family members have a history of mental illness (depression, anxiety, attention deficit disorder, addictions, **etc.**)?-----

Has anyone close to you committed suicide or attempted to commit suicide? _____

Is there anything that troubles you about your childhood (family, school, social, etc.)? _____

Other...

Is there anything else you feel is important for your counselor to know _____

Thank you for taking the time to answer these questions.