Wilsonville Counseling Center
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503-349-1705

Client Information:

Client Name: ____ Date: _____________

Gender: ☐ Male ☐ Female Age: _____________ Date of Birth____________

Home Address: ____

City/State: ____ Zip Code: _____________

Home Phone:____________________ Okay to leave a message? ☐ Yes ☐ No

Work Phone: ____________________ Okay to leave a message? ☐ Yes ☐ No

Cell Phone:______________________ Okay to leave a message? ☐ Yes ☐ No

Email address: ____________________________________

Emergency Contact ____
Name Relationship Phone

Ethnic Background____

Spiritual Practice/ Religious Affiliation:____

Educational Background: ____

Occupation: ____

Referral Source:____

Previous Counseling:

Type of treatment (inpatient/outpatient)	Provider	First Seen	Last Seen	Helpful?

Primary Insurance Information:

Name of Insurance Holder (Insured): ____

Insured Birth Date: ________________________

Employer: ________________________ Health Plan: _____________________________

Client's Relationship to the Insured: ____

Member number: ____________________ Policy/ Group number: ___________________

Insurance Co. Contact Phone Number: ____

Insurance Co. Address: ____

Secondary Insurance Information:

Name of Insurance Holder (Insured): ____

Insured SSN: _____________________ Insured Birth Date: ________________________

Employer: ________________________ Health Plan: _____________________________

Client's Relationship to the Insured: ____

Member number: ____________________ Policy/ Group number: ___________________

Insurance Co. Contact Phone Number: ____

Insurance Co. Address: ____

******Please bring a copy of your insurance card and driver's license to the first session.*******

Family Information:

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Single

Spouse/ Partner's Name: ______________________________ Age:________

Previous Marriages: ____

Children (Include all biological, adopted, foster, and step):

Name	Sex	Age	Type (B,A,F, S)	Custody Y/N	Lives with
________________	____	____	_________	______	________________
________________	____	____	_________	______	________________
________________	____	_____	_________	______	________________
________________	____	_____	_________	______	________________

Family History:

Father
Name: ___________________________Rate Relationship (1 poor to 5 great)________

Mother
Name: ___________________________Rate Relationship (1 poor to 5 great) ________

Step parents
Name:____________________________Rate Relationship (1 poor to 5 great) ________
____

Do you have any brothers and sisters (including step, foster, and adopted)? __________
If yes how many and birth order:
____
____
____
____
____

Any family history of psychological, Emotional, Serious Medical Illness, or Substance abuse issues:
____

Medical History:

Do you have a primary care physician? ☐ Yes ☐ No
Name:______________________________ Phone number:__________________

Are you presently under a physician's care? ☐ Yes ☐ No
If yes, What for?

____

____

Do you see any other healthcare providers?
Chiropractor ☐ Naturopathic Doctor ☐ Acupuncture ☐

Bio-feed back☐ Massage Therapy ☐ Other ☐______________________

Do you have any allergies? ____

Prescription medications currently taking (include name, dosage, and frequency)

____

____

Any over the counter medication, vitamins, sleep aids, other supplements

____

____

Lifestyle/ Habits:

Habits	**Times per week**	**Most Ever Used**	**Current or past**
Caffeine coffee/ soda			
Cigarettes, cigars, pipes			
Prescription Medication			

Substance Use/ Abuse History:
Have you ever used drugs or alcohol? ☐ Yes ☐ No
If yes please describe:

Substance	**Amount**	**Frequency**	**Last use**

Name: ________________________________

Problem Check List (Check all that apply)

Issue	Past Problem	Present Problem
Physical Problem (______________)		
Substance Use (______________)		
Irregular Eating		
Sleep problems		
Performance at School		
Performance at Work		
Performance at Home		
Difficulty Making Friends		
Difficulty Understand Others		
Shyness		
Feeling Victimized		
Feeling Rejected		
Unable to Have a Good Time		
Feeling cut off from others		
Communication Problems		
Sexual Problems		
Financial Problems		
Fear of: ( )		
Can’t Stop Thinking about : ( )		
Feel Depressed		
Feel Inferior		
Feel Emotionally Numb		
Lack of Confidence		
Excessive Worrying		
Can’t Make Decisions		
Low Energy		
Forgetfulness		
Lack of Goals		
Unable to Cope with Day to Day Life		
Afraid of Being on My Own		
Suicidal Thoughts		
Feeling Tense		
Feeling Anxious		
Feeling Angry		
Physical Aggression/Violence		
Can’t Sit Still		
Overly Ambitious		
Unable to Relax		
Seeing or Hearing Things Others Do Not		
Nightmares		

Issue	Past Problem	Present Problem
Affairs (emotional, sexual)		
Addiction: substance, food, sex, shopping, gambling		
Issues related to a loss		
Loneliness		
Problems Coping		
Legal problems		
Marriage Issues		
Relationship Issues		
Family Conflict		
Behavioral Problems		
Loss of Interest or Pleasure		
Difficulty Focusing		
Poor Concentration		
Hopelessness		
Worthlessness		
Persistent Guilt		
Irritability		
Change in appetite or weight		
Mood Swings		
Nervousness		
Panic Attacks		
Social Anxiety		
Obsessive Thoughts		
Racing Thoughts		
Compulsive Behaviors		
Easily Distracted		
Impulsive Decision/Behaviors		
Impatience		
Difficulty Finishing Projects		
Low Self-Esteem		
Difficulty saying No		
Fear of Rejection		
Separation/ Divorce		
Anger Issues/ Temper		
Hurting Others		
Hurting Self		
High Risk Behaviors		
Other:		