



Discover Counseling

7320 SW Hunziker St., Suite 204 | Tigard, OR 97223

Phone: 971.222.8166 | Fax: 866.802.8062

Email: contact@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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Overall, your family life growing up was:

<input type="checkbox"/>	Supportive	<input type="checkbox"/>	Loving	<input type="checkbox"/>	Chaotic	<input type="checkbox"/>	Confusing	<input type="checkbox"/>	Affirming
<input type="checkbox"/>	Strict	<input type="checkbox"/>	Hostile	<input type="checkbox"/>	Safe	<input type="checkbox"/>	Unsafe	<input type="checkbox"/>	Negative

How did your family deal with conflict growing up:

<input type="checkbox"/>	Yell or scream	<input type="checkbox"/>	Physical aggression	<input type="checkbox"/>	Talking/listening	<input type="checkbox"/>	Ignoring <i>people</i>
<input type="checkbox"/>	Ignoring <i>issues</i>	<input type="checkbox"/>	Isolating (silent treatment)	<input type="checkbox"/>	Safe	<input type="checkbox"/>	Guilt or manipulation

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: _____



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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?	<input type="checkbox"/> Whether the client is in treatment or not <input type="checkbox"/> Prognosis (diagnosis, opinion of how treatment will benefit client, general peculiarities of case) <input type="checkbox"/> 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) <input type="checkbox"/> Brief statement regarding relapse and frequency of relapse (cannot identify specific drugs)
Purpose of Release Why is information being released?	<input type="checkbox"/> Referral to other services <input type="checkbox"/> Coordination of care <input type="checkbox"/> Consultation with Doctor <input type="checkbox"/> Consultation with other mental health provider <input type="checkbox"/> Transfer of care <input type="checkbox"/> 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.