Alliance™
COUNSELING CENTER

HARMONY IN MOTION
Equine Assisted Psychotherapy Program

Individual/Family Intake Form

Counseling & Psychotherapy
818 NW 17th Avenue, Portland, Oregon 97209
Phone: 503-221-4531 • Fax: 503-263-6278
www.AllianceCounselingCenter.org

Today's date:

Personal Information

Client name: Age: Sex:

Date of birth: Maritial Status: SSN:

Parent/guardian name: Age: Sex:

Partner's name: Age: Sex:

Address: Home phone:

City/State/ZIP: Work phone:

Number of children: Ages/Sex: Mobile phone:

Nearest relative living separately: Contact phone:

Education/Occupation

Highest level of education:

High level of education of parent/guardian:

Present occupation: Company name:

Main occupation during last 5 years:

Medical Insurance

Insurance name: Phone number:

Address: ID#:

City/State/ZIP: Group number:

General Information

How did you hear about us:

Problems you want help with:

Describe your education:

Describe your living situation:

How much have you worked in the past 2 years:

Describe any psychological problems you have had (e.g. periods of depression, anxiety, fears, phobias, anger, confusion, etc…):

Has there been any deaths in your immediate/extended family: If so, how long ago:

If so, who:

Other family/friends/pet deaths:

When did a physician last examine the client:

Name of physician: Phone:

List any major health problems for which you have received treatment:

Do you or your family members currently have or have ever had any of the following (please check all that apply):

Heart problems	❑ Self	❑ Family	❑ Children
Cancer	❑ Self	❑ Family	❑ Children
Anxiety	❑ Self	❑ Family	❑ Children
Stroke	❑ Self	❑ Family	❑ Children
Eating disorder	❑ Self	❑ Family	❑ Children
Alcohol/drug abuse	❑ Self	❑ Family	❑ Children
Legal problems	❑ Self	❑ Family	❑ Children
Learning disability	❑ Self	❑ Family	❑ Children
Depression	❑ Self	❑ Family	❑ Children
Other	❑ Self	❑ Family	❑ Children

List any medications you are now taking (prescriptions and/or over the counter):

Have you or your child ever received psychological help or counseling before:

If so, please describe:

Have you ever been assaulted:

Have you or your child ever witnessed abuse/violence within your family:

Please everyone currently living in your home:

Name	Age	Relationship	Occupation

Please circle any of the following that is a concern to you or your child:

Nervousness	Depression	Fears	Shyness	Physical abuse
Sexual problems	Suicidal thoughts	Separation	Divorce	Bowel troubles
Finances	Anger	Self-control	Friends	Being a parent
Sleep problems	Stress	Work/school	Relaxation	Bizarre thoughts
Headaches	Tiredness	Legal problems	Memory	Stomach problems
Ambition	Hyperactivity	Nightmares	Making decisions	Gambling
Loneliness	Low self-esteem	Concentration	Education/grades	Binge Eating
Career	Marriage/relationships	Health problems	Temperment	Eating too little
Children	Defiant behavior	Unhappiness	Sexual abuse	Eating too much
Road rage	Fighting	Bed wetting	Perfectionism	Panic
Impulsiveness	Drug/alcohol use	Stealing	Lying	Obsessiveness

Please circle any of the following strengths that would describe yourself or your child:

Confident	Hard worker	Organized	Sympathetic	Good listener
Dependable	Sensitive	Logical	Loyal	Compassionate
Decisive	Responsible	Understanding	Funny/Humorous	Loving
Intelligent	Communicative	Likeable	Attractive	Decent
Spiritual	Creative	Fun-loving	Passionate	Athletic
Ambitious	Sympathetic	Respectful	Ethical	Caring

Please use the chart below to describe your use of drugs/alcohol use:

	Age first used	Frequency of use	Last used
Tobacco			
Alcohol			
Marijuana			
Cocaine			
Crack			
Crank			
Amphetamine/Speed			
Hallucinogens			
Coffee			
Other			