

Counseling & Psychotherapy  
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www.AllianceCounselingCenter.org

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Today's date:

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### Personal Information

Client name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Marital 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.....      | <input type="checkbox"/> Self | <input type="checkbox"/> Family | <input type="checkbox"/> Children |
| Cancer .....             | <input type="checkbox"/> Self | <input type="checkbox"/> Family | <input type="checkbox"/> Children |
| Anxiety.....             | <input type="checkbox"/> Self | <input type="checkbox"/> Family | <input type="checkbox"/> Children |
| Stroke.....              | <input type="checkbox"/> Self | <input type="checkbox"/> Family | <input type="checkbox"/> Children |
| Eating disorder .....    | <input type="checkbox"/> Self | <input type="checkbox"/> Family | <input type="checkbox"/> Children |
| Alcohol/drug abuse.....  | <input type="checkbox"/> Self | <input type="checkbox"/> Family | <input type="checkbox"/> Children |
| Legal problems.....      | <input type="checkbox"/> Self | <input type="checkbox"/> Family | <input type="checkbox"/> Children |
| Learning disability..... | <input type="checkbox"/> Self | <input type="checkbox"/> Family | <input type="checkbox"/> Children |
| Depression .....         | <input type="checkbox"/> Self | <input type="checkbox"/> Family | <input type="checkbox"/> Children |
| Other.....               | <input type="checkbox"/> Self | <input type="checkbox"/> Family | <input type="checkbox"/> 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:

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

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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
<b>Tobacco</b>			
<b>Alcohol</b>			
<b>Marijuana</b>			
<b>Cocaine</b>			
<b>Crack</b>			
<b>Crank</b>			
<b>Amphetamine/Speed</b>			
<b>Hallucinogens</b>			
<b>Coffee</b>			
<b>Other</b>			