Patricia Rohani LPC, LMFT
counseling for your journey
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503.896.67962(cell/confidential voice mail)

Today's Date _____

Client Name:_____

Age:_____ DOB:_____

Address: _____City: _____ State: ____ Zip: _____

Home Phone: _____ Ok to leave message? __ YES __ NO

Cell Phone: _____ Ok to leave message? __ YES __ NO

Email: _____ Ok to leave message? __ YES __ NO

Current Employer (or school if a student): _____

Gender: Male __ Female __ Who referred you: _____

WHOM MAY I CONTACT IN CASE OF EMERGENCY:

_____

Daytime Phone: _____ Evening Phone:_____

Spouse's Name (if applicable): _____ Age: _____ DOB: _____

Current Marital Status

__ Single

__ Married (duration: _____)

__ Unmarried, living together (duration: _____)

__ Separated (duration: _____) Divorced (duration: _____)

__ Widowed (duration: _____)

Education

Currently in school: __ YES __ NO Total years of education: _____

Employment

Are you currently employed: __ YES __ NO

Current Employer: _____

Job Title: _____

Length of time employed: _____

Job responsibilities: _____

Level of stress of job: _____

Legal

Are you involved in any legal activities (civil, criminal, custody, probation/parole, etc)?

__ YES __ NO

If yes, please describe:

_____

Military Experience

Military experience? __ YES __ NO (if no, skip this section)

Branch of Service: _____ Date enlisted/drafted: _____

Discharge date: _____ Type of discharge: _____ Rank at discharge_____

Combat experience?: __ YES __ NO Other stressors experienced:_____

PRESENTING PROBLEMS/CONCERNS

Describe the problem that brought you here today:

_____

_____

_____

What do you hope to gain from therapy:

_____

_____

_____

If married or in a significant relationship, how satisfied are you with your relationship? Are there problems or concerns relationally or sexually:

_____

_____

_____

How important are spiritual matters to you? __ Not at all __ Little __ Somewhat __ Very much

Are you affiliated with a particular spiritual or religious group? __ YES __ NO

If yes, please describe: _____

Would you like your spiritual/religious beliefs incorporated into the counseling? __ YES __ NO

Comments:_____

_____

_____

_____

Please check behaviors and symptoms that occur to you more often than you would like:

	aggression/fighting		eating disorder		loneliness
	alcohol abuse		elevated mood		memory problems
	angry outbursts		fatigue		mood swings
	arguments/conflicts		gambling		panic attacks
	avoiding people		hallucinations		phobias/fears
	anxiety		heart palpitations		racing thoughts
	attention difficulties		homicidal thoughts		sleeping problems
	chest pain		hopelessness		sexual addictions
	computer addiction		impulsivity		sexual difficulties
	depression		irritability		suicidal thoughts
	dizziness		intrusive thoughts		worrying
	drug abuse		judgment errors		

*Please add any other symptoms or behaviors not mentioned

Briefly describe how the above checked symptoms impair your ability to function effectively:

_____

_____

_____

Have you ever had thoughts or made statements of wanting to hurt yourself or seriously hurt someone else? __ YES __ NO. If YES, please describe the situation:

_____

_____

Have you ever purposely hurt yourself or another? __ YES __ NO. If YES, please describe the situation:

_____

_____

PRIOR MENTAL HEALTH TREATMENT

Type of Treatment	**No**	**Yes**	**Start/End Dates**	**Provider name/ primary reason for treatment**
Counseling or Psychiatric Care:				
Drug/Alcohol Treatment:				
Psychiatric Hospitalization:				
Self-help/support group:				

Current Primary Care Physicians Name_____

Current medications: __ None

Medication & Dosage	Date First Prescribed	Prescribed By
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Children: List each child's name and (Male/Female) on top of each column. Include step- and foster children. Check appropriate boxes to indicate child's relationship to you if other than biological. Indicate if the child has special medical, behavior, or academic concerns.

Children	Name (M/F)	Name (M/F)	Name (M/F)	Name (M/F)	Name (M/F)
Age					
Other Parent's Name					
Adopted Child; Check if yes					
Step Child; Check if yes					
Foster Child; Check if yes					
Put X if child lives with you					
Medical Concerns:					
Social/Behav. Concerns:					
Academic Concerns:					
Put X if child is deceased					

Is there anything happening NOW in your current living situation or in your family that is especially stressful for you?

_____

_____

Please check if you have suffered any of the following types of trauma:

___ Neglect	___ Emotional abuse	___Physical abuse
___ Sexual abuse	___ Loss of loved one	___ Natural disaster
___ Teenage pregnancy	___ Parental substance abuse	___ Crime victim
___ Violence in the home	___ Parents separated or divorced	___ Financial problems
___ Parental illness	___ Homelessness	___ Lived in foster home
___ Multiple family moves	___Other (please explain): _____	

_____

Please comment on any of the above checked items (including your age when the trauma occurred and the details of the traumatic event):

_____

_____

_____

To which cultural or ethnic group do you belong? _____

Are you experiencing any difficulties due to cultural or ethnic issues? If yes, please describe:

_____

_____

CHEMICAL USE HISTORY

Substance Type	Current Use (within the last 6 months)	Frequency	Amount	Past Use	Frequency	Amount
Tobacco						
Caffeine						
Alcohol						
Marijuana						
Cocaine/crack						
PCP/LSD						
Heroin/opiates						
Methamphetamines						
Benzodiazapines (valium, ativan, xanax etc.)						
Inhalants						
Other:						

Have you had withdrawal symptoms when trying to stop using any substances? __ YES __ NO.

If YES, please describe the situation:

_____

_____

Have any substances created a problem for you at work or home? __ YES __ NO.

If YES, please describe the situation:

_____

_____

_____

SOCIAL/CULTURAL HISTORY

Please check how you generally get along with other people: (check all that apply)

__ Affectionate __ Aggressive __ Avoidant __ Fight/argue often __ Follower __ Assertive

__ Friendly __ Leader __ Outgoing __ Shy/withdrawn __ Submissive

Describe special areas of interest or hobbies (i.e. art, books, crafts, physical fitness, etc.)

Activity	How often now?	How often in the past?

Please describe your strengths, skills and talents:

_____

_____

_____

Please note any other concerns, problems, or areas of need that you may want me to know about.

_____

_____

_____