Willamette Valley Family Center, LLC
610 Jefferson Street - Oregon City, Oregon 97045 ---- Phone (503) 657-7235 Fax (503)657-7676

CLIENT INTAKE EVALUATION

1. IDENTIFYING INFORMATION

Client's Name:	Today's Date:	Referred By:
Partner's name (if being seen as a couple):		

Gender: M ☐ F ☐ Age: _____ Birth Date: _____ (mm/dd/yyyy) Marital Status: _____

Home address: _____ (Street) (City) (State) (Zip)

Telephone: _____ (home) (client (work)) (client (cell phone))

May we leave messages for you at home? Yes ☐ No ☐ May we leave messages for you at work? Yes ☐ No ☐

Others living in the home: _____ (name, birthdate, relationship to client) _____ (name, birthdate, relationship to client)

_____ (name, birthdate, relationship to client) _____ (name, birthdate, relationship to client) _____ (name, birthdate, relationship to client)

Education (self): _____ Partner: _____

Occupation (self): _____ Partner: _____

Client's Employer: _____

Social Security (ID) Number (self): _____ E-mail Address: _____

Emergency contact: _____ Phone: _____

Insurance Information

Name of subscriber: _____ Date of Birth: _____ (mm/dd/yyyy)

Address of subscriber: _____ (Street) (City) (State) (Zip)

Relationship of client to subscriber: _____

Employer of subscriber: _____

Insurance Company: _____ Phone: _____

Insurance Company Address: _____ (Street) (City) (State) (Zip)

Insurance Identification Number: _____ Group Number: _____

Secondary insurance: _____ Phone: _____

Name of secondary subscriber: _____ Date of Birth: _____ (mm/dd/yyyy)

Secondary company address: _____ (Street) (City) (State) (Zip)

Secondary identification number: _____ Group number: _____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to provider of services.

_____

Signature (Insured) Date

Client Name: _____

2. PRESENTING PROBLEM

Describe the problem that brought you here today:

Check any of the symptoms that you are having:			
Depression		Feeling hopeless	
Extreme sadness		Feeling tearful	
Trouble concentrating		Change in sleeping habits	
Memory problems		Lack of energy	
Change in eating habits		Weight changes	
Feelings of extreme happiness		Change in sexual interest or function	
Trouble performing your job		Problems getting along with friends or family	
Lack of enjoyment of usual activities		Feeling stressed	
Self-esteem problems		Easily irritated	
Perfectionism		Feeling guilty	
Obsessions or compulsions		Feeling nervous	
Feeling fearful		Sudden feelings of panic	
Physical complaints of pain		Muscle tension	
Problems with anger		Acting violently	
Thoughts about hurting yourself or others		Thoughts about killing yourself or others	

Continue on next page

Client Name:_____

3. HAVE YOU EVER BEEN IN COUNSELING BEFORE? **Yes** ☐ **No** ☐

If you have been in counseling before, please describe it below. Start with most recent time first.

A. When did you have counseling?	Date (s):
Who did you see?	Name:
Explain what happened:	
B. When did you have counseling?	Date (s):
Who did you see?	Name:
Explain what happened:	

4. MEDICAL INFORMATION

Have you seen a doctor within the past year?	Yes ☐	No ☐
Why have you seen a doctor?		
Who is your doctor?	Phone:	
Are you taking any kind of medications? (Prescription or over-the-counter)?	Yes ☐	No ☐
Please list any medications that you are taking:		
Do you have allergies to anything?	Yes ☐	No ☐
Describe any allergy problems that you may have:		

5. SUBSTANCE USE HISTORY

Do you use/have you used tobacco (any form?)	Current ☐	Past ☐	No ☐
Do you use/have you used alcohol?	Current ☐	Past ☐	No ☐
Do you use/have you used caffeine (any form including cola drinks)?	Current ☐	Past ☐	No ☐
Do you use/have you used recreational drugs?	Current ☐	Past ☐	No ☐