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

CLIENT INTAKE EVAULATION

Partner's name if being seen as a couple: render: M	. IDENTIFYING INFORMATION				
forme address: Street	Client's Name:	Today's Date:	Referred By:		
City State Z Z	Partner's name if being seen as a couple:		-		
forme address: Street	Gender: M F Age: Birth Date	e: Marita	ıl Status:		
Telephone: (home)	Home address:	mm/dd/yyyy			
Client (work) Client (work) Client (cell phone)	Street	City	State	Zip	
May we leave messages for your at home? Yes No May we leave messages for your at work? Yes No Others living in the home: (name, birthdate, relationship to client)	Telephone: (home)	client (work)	client (cell phone)		
(name, birthdate, relationship to client) (name, birthdate, relationship to client) (name, birthdate, relationship to client) Partner: Occupation (self): Partner: Client's Employer: Social Security (ID) Number (self): Emergency contact: Phone: Insured date of birth: Address of insured person: Street City State Z Relationship of client to insured person: Employer of insured person: Insurance Company: Insurance Company: Phone: Insurance Identification Number: Secondary insurance: Phone: Secondary insurance: Date of Birth: mm/dd/yyyy Secondary company address: Street City State Z Street City State Z Secondary company address: Street City State Z Secondary company address: Street City State Z Street Street City State Z Secondary company address: Street City State Z Street Street City State Z Street Street Street City State Z Street St	` '		_	s 🗌 No 🗌	
(name, birthdate, relationship to client) Partner: Decupation (self): Partner: Client's Employer: Social Security (ID) Number (self): Emergency contact: Insured Information Name of insured: Street City State Zelationship of client to insured person: Employer of insured person: Employer of insured person: Employer of insured Company: Insurance Company Address: Street City State Zensurance Identification Number: Secondary insurance: Phone: Secondary insurance: Phone: Date of Birth: Insured date, relationship to client (name, birthdate, relationship to client Partner: Phone: Street City State Zengla Address: Employer of insured date of birth: Insurance Company: Street City State Zengla Address: Insurance Insurance Identification Number: Secondary insurance: Phone: Secondary insurance: Date of Birth: Insurance Insura	Others living in the home:				
Address of insured person: Street City State	(name, birthdate, re	lationship to client)	(name, birthdate, relation	ship to client)	
Cocupation (self):	(name, birthdate, relationship to client)	(name, birthdate, relationship to client	(name, birthdate, relation	nship to client	
Client's Employer: Social Security (ID) Number (self): Email Address: Phone: Insurance Information Name of insured: Street City State Thone: Insured date of birth:	Education (self):	Pa	rtner:		
Client's Employer: Social Security (ID) Number (self): Email Address: Phone: Insurance Information Name of insured: Street City State Thousian Company: Insurance Company: Insurance Company Address: Street City State Thousian Company Address: Insurance Identification Number: Secondary insurance: Phone: Insurance Company address: Street City State Thousian Company Number: Secondary insurance: Date of Birth: Insurance Company address: Street City State Thousian Company Number: Secondary company address: Street City State Thousian Company Number: Secondary insurance: Secondary insurance: Secondary company address: Street City State Thousian Company Street Street City State Street Street City State	Occupation (self):	Pa	rtner:		
Social Security (ID) Number (self): E-mail Address: Emergency contact: Phone: Insurance Information	Client's Employer:				
Insured date of birth: Mame of insured:			mail Address:		
Name of insured:	Emergency contact:	Ph	one:		
Address of insured person: Street City State Z Relationship of client to insured person: Employer of insured person: Insurance Company: Street City State Phone: Insurance Company Address: Street City State Group Number: Secondary insurance: Phone: Secondary insurance: Date of Birth: mm/dd/yyyy Secondary company address: Street City State Z City State	Insurance Information				
Address of insured person: Street City State Zelationship of client to insured person: Employer of insured person: Insurance Company: Insurance Company Address: Street City State Zerondary insurance: Date of Birth: Insurance Company address: Street City State Zerondary insurance: Secondary company address: Street City State Zerondary State	Name of insured:		Insured date of birth:		
Relationship of client to insured person: Employer of insured person: Insurance Company: Street City State Total Company Number: Secondary insurance: Name of secondary insured: Secondary company address: Street City State Total Company Number: Date of Birth: mm/dd/yyyy Secondary company address: Street City State Total Company Number: City State Total Company Number: Secondary insurance: Date of Birth: mm/dd/yyyy	Address of insured person:			mm/dd/yyyy	
Employer of insured person: Insurance Company: Street City Group Number: Secondary insurance: Phone: Date of Birth: mm/dd/yyyy Street Street City State Z				Zip	
nsurance Company: Phone: Street City State Z nsurance Identification Number: Group Number: Phone: Phone: Secondary insurance: Phone: Date of Birth:	Relationship of client to insured person:				
Insurance Company Address: Street City State Z Group Number: Secondary insurance: Name of secondary insured: Secondary company address: Street City State Z Group Number: Phone: mm/dd/yyyy Secondary company address: Street City State Z	Employer of insured person:				
Street City State 2 Insurance Identification Number: Group Number: Phone: Secondary insurance: Date of Birth: Secondary company address: Street City State 2	nsurance Company:		Phone:		
Street City State 2 Insurance Identification Number: Group Number: Phone: Secondary insurance: Date of Birth: Secondary company address: Street City State 2	nsurance Company Address:				
Secondary insurance: Phone:			State	Zip	
Name of secondary insured: Secondary company address: Street City Date of Birth: mm/dd/yyyy State Z	nsurance Identification Number:		Group Number:		
Secondary company address: Street City State 2	Secondary insurance:		Phone:		
Secondary company address: Street City State 2	Name of secondary insured:				
	Secondary company address:	C'	mm/dd/yyyy		
Oroup numoci.				Zip	
PATIENT OR AUTHORIZED PERON'S SIGNATURE: I authorizer the release of any medical or other information necessary to process a claim					
	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
Feeling 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 other side

If you have been in counseling before, ple	ase describe it below. Start wit	h most recent tin	ne 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	ar?		Yes [No
Why have you seen a doctor?				
Who is your doctor?	P	hone:		
Are you taking any kind of medications? (prescription or over –the counter)? Yes No				
Please list any medications that you are tal	king:			
Do you have allergies to anything?			Yes [□ No □
Describe any allergy problems that you man	ay have:			
5. SUBTANCE USE HISTORY			T	
Do you use/have you used tobacco (any fo	orm?)	Current	Past	No 🗌
Do you use/have you used alcohol?		Current	Past	No 🗌
Do you use/have you used caffeine (any fo	orm including cola drinks)?	Current	Past	No 🗌
Do you use/have you used recreational dru		Current	Pact	No \square

3. HAVE YOU EVER BEEN IN COUNSELING BEFORE? Yes

No 🗌