

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: _____ Marital Status: _____

mm/dd/yyyy

Home address: _____
Street City State Zip

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

Reminder Call Preference : Text # _____ Automated Voice Call Office Staff to Call NO CALL

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 <input type="checkbox"/>	No <input type="checkbox"/>
Why have you seen a doctor?		
Who is your doctor?	Phone:	
Are you taking any kind of medications? (Prescription or over-the-counter)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Please list any medications that you are taking:		
Do you have allergies to anything?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Describe any allergy problems that you may have:		

5. SUBSTANCE USE HISTORY

Do you use/have you used tobacco (any form?)	Current <input type="checkbox"/>	Past <input type="checkbox"/>	No <input type="checkbox"/>
Do you use/have you used alcohol?	Current <input type="checkbox"/>	Past <input type="checkbox"/>	No <input type="checkbox"/>
Do you use/have you used caffeine (any form including cola drinks)?	Current <input type="checkbox"/>	Past <input type="checkbox"/>	No <input type="checkbox"/>
Do you use/have you used recreational drugs?	Current <input type="checkbox"/>	Past <input type="checkbox"/>	No <input type="checkbox"/>