COUNSELING ON BURNSIDE
2303 E. Burnside Street | Portland, OR 97214
(503) 827-3644

Client Information

A. Identification

Name:_____ Date:_____

Chief Concerns
Please describe the main difficulty that has brought you to seek counseling:

Please mark all the items that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

( ) Abuse – physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
( ) Aggression, violence
( ) Alcohol use
( ) Anger, hostility, arguing, irritability
( ) Anxiety, nervousness
( ) Attention, concentration, distractibility
( ) Career concerns, goals, choices
( ) Childhood issues (your own childhood)
( ) Codependence
( ) Confusion
( ) Compulsions
( ) Custody of children
( ) Decision making, indecision, mixed feelings, putting off decisions
( ) Delusions (false ideas)
( ) Dependence
( ) Depression, low mood, sadness, crying
( ) Divorce, separation
( ) Drug use – prescription medications, over-the-counter medications, street drugs
( ) Eating problems – overeating, under eating, appetite, vomiting (see also "Weight and diet issues")
( ) Emptiness
( ) Failure
( ) Fatigue, tiredness, low energy
( ) Fears, phobias
( ) Financial or money troubles, debt, impulsive spending, low income
( ) Friendships
( ) Gambling
( ) Grieving, mourning, deaths, losses, divorce
( ) Guilt

( ) Headaches, other kinds of pains
( ) Health, illness, medical concerns, physical problems
( ) Housework/chores – quality, schedules, sharing duties
( ) Inferiority feelings
( ) Interpersonal conflicts
( ) Impulsiveness, loss of control, outbursts
( ) Irresponsibility
( ) Judgment problems, risk taking
( ) Legal matters, charges, suits
( ) Loneliness
( ) Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
( ) Memory problems
( ) Menstrual problems, PMS, menopause
( ) Mood swings
( ) Motivation, laziness
( ) Nervousness, tension
( ) Obsessions, compulsions, (thoughts or actions that repeat themselves)
( ) Oversensitivity to rejection
( ) Panic or anxiety attacks
( ) Parenting, child management, single parenthood
( ) Perfectionism
( ) Pessimism
( ) Procrastination, work inhibitions, laziness
( ) Relationship problems (with friends, with relatives, or at work)
( ) School problems (see also (Career concerns……")
( ) Self-centeredness
( ) Self esteem
( ) Self neglect, poor self care
( ) Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
( ) Shyness, oversensitivity to criticism
( ) Sleep problems – too much, too little, insomnia, nightmares
( ) Smoking and tobacco use
( ) Spiritual, religious, moral, ethical issues
( ) Stress, relaxation, stress management, stress disorders, tension
( ) Suspiciousness
( ) Suicidal thoughts
( ) Temper problems, self-control, low frustration tolerance
( ) Thought disorganization and confusion
( ) Threats, violence
( ) Weight and diet issues
( ) Withdrawal, isolating
( ) Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition

Any other concerns or issues:

Please look back over the concerns you have checked off and choose the one that you most want help with. It is:

B. Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before? ~ No ~ Yes ~ If yes, please indicate:

When? From Whom? For what? With what results?

Have you ever taken medications for psychiatric or emotional problems? ~ No ~ Yes ~ If yes, please indicate:

When? From Whom? Which medications? For what? With what results?

C. Relationships in your family of origin. Please describe the following:

1. Your parents' relationship with each other:

2. Your relationship with each parent and with other adults present:

3. Your parents' physical health problems, drug or alcohol use, and mental or emotional difficulties:

4. Your relationship with your brothers and sisters, in the past and present:

D. Abuse History: ~ I was not abused in any way. ~ I was abused. If you were abused, please indicate the following. For kind of abuse, use these letters**: P** = Physical, such as beatings. **S** = Sexual, such as touching/molesting, fondling, or intercourse. **N** = Neglect, such as failure to feed, shelter, or protect. **E** = Emotional, such as humiliation, etc.

Your Age	Kind of Abuse	By Whom?	Effects on You?	Whom Did You Tell:	Consequences of Telling?

E. Present relationships

1. How do you get along with your present spouse or partner?

2. How do you get along with your children?

3. Your important friends, past and present:

F. Chemical Use

1. Have you ever felt the need to cut down on your drinking? No Yes
2. Have you ever felt annoyed by criticism of your drinking? No Yes
3. Have you ever felt guilty about drinking: No Yes
4. Have you ever taken a morning 'eye-opener'? No Yes
5. How much beer wine or hard liquor do you consume each week, on the average?_____
6. Are there times when you drink to unconsciousness, or run out of money as a result of drinking? Yes No
7. How much tobacco do you smoke or chew each week? _____
8. Have you ever used inhalants ('huffing') such as glue, gasoline, or paint thinner? Yes No
9. Which drugs (not medications prescribed for you) have you used in the last 10 years? _____

G. Other

Is there anything else that is important for your therapist to know about, and that you have not written about on any of these forms? If yes, please tell us about it here or on another sheet of paper.