Counseling on Burnside
2303 E. Burnside St., #203
Portland, OR 97214
(503) 827-3644

Name:_____ Date:_____

Who Referred you to me?_____ **I give permission for you to send a thank you note to this person: ___ Yes ___ No**

Your Address:_____ City:_____ State:_____ Zip:_____

Home Tel:_____ May We Leave A Message? Yes___ No__

Cell Ph:_____ May We Leave A Message? Yes___ No__

Work Ph:_____ May We Leave A Message? Yes___ No__

Date of Birth:_____ Sex: M / F Marital Status: M__S__D__W__

Email:_____ May we email you? Yes__ No__

Spouse __ Partner __ Do we have authorization to discuss your account with him or her? Yes__ No__

Name of Spouse or Partner:_____

Who is responsible for paying your bill? If other than you, fill out below and responsible party must sign this form:

Name of Responsible Party: _____ Relationship to you:_____

Address if different:_____ City:_____State:_____ Zip:_____

Home Ph:_____

Your Primary Insurance: _____ Your Secondary Insurance:_____

Subscriber #_____Group#_____ Subscriber #:_____ Group #:_____
If Subscriber is other than you:
please fill out their Address if different:_____City_____ Zip_____

- I understand that I am fully responsible for all professional fees not covered by this assignment of insurance benefits.
- I understand that payment in full is due at the time of service unless prohibited by my Provider's contract with my insurer.
- I authorize my insurance company to pay medical benefits to the provider of services, Joseph Alexander.
- I hereby authorize the release of any medical or other information necessary to process insurance claims for services provided by Joseph Alexander.

Responsible Party's Signature:_____ Date:_____

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Date_____

Intake Counselor _____

Name _____ Gender_____
DOB _____ Ethnicity _____
Sexual orientation: _____
Marital Status: **Single/Never married/ Domestic partnership/ Married /Separated/ Divorced/ Widowed**
How many years? _____ Name of spouse/significant other? _____
On a scale of 1-10 (*10 being best*) how would you rate your relationship_____
Names and ages of children or others living in the home: _____
_____
Occupation/Job Title: _____ Employer/School: _____
Religion/Spirituality: _____

Presenting Problem and Symptoms:
What is your primary reason for seeking counseling? _____
_____
_____

In the past two weeks, how often have you experienced the following:

	Never	Sometimes	Often
Feeling sad or down			
Low self-esteem			
Feeling irritable or easily frustrated			
Loss of interest in activities you normally enjoy			
Low motivation			
Difficulty concentrating			
Feeling hopeless			
Social isolation			
Anxiety, nervousness or fear			
Unexpected feelings of panic			
Obsessions/compulsions			
Frequent worrying			
Feeling tense or stressed			
Racing thoughts			
Aggressive behaviors			

	Never	Sometimes	Often
Change in sleeping patterns (insomnia or hypersomnia)			
Change in appetite (increase/decrease)			
Restricted your food intake or regurgitated your food			
Worried about your appearance or weight			
Self-injury behavior (cutting, burning, or otherwise hurting self)			
Thoughts of suicide			
Feeling numb or detached			
Nightmares or flashbacks			
Risky or impulsive behavior			

Physical Health/Medical Information:

Name and phone of primary care physician_____
Do you have any medical conditions? _____
How would you rate your physical health currently? (poor, un-satisfactory, good, very good)
Do you experience chronic pain? Y or N
Have you ever been prescribed medication for psychiatric or mental health reasons? Y or N
Are you currently taking any prescription medications? _____
_____
Do you take any herbal remedies or supplements? _____
_____
How many hours are you sleeping per night on average? _____
Do you engage in regular physical exercise? Y or N
Please describe_____

Previous mental health treatment:

Do you have a history of self-injurious behavior (cutting, burning or otherwise hurting yourself)? Y or N
Do you have a history of suicidal ideation or past suicide attempts? Y or N
Have you ever received mental health treatment (psychological, drug or alcohol treatment, or counseling services?) Y or N
When/where? _____
_____
Did you find it helpful? Y or N
Have you ever been hospitalized for mental health reasons? Y or N
When/where? _____

Adverse life experiences:

Do you have a history of trauma or upsetting life events? Y or N
If yes, please explain: _____
_____

Have you ever experienced verbal or emotional abuse? Y or N
Have you ever experienced physical abuse? Y or N
Have you ever experienced childhood sexual abuse or a past sexual assault? Y or N

Is there a family history of any of the following?

	Family member
Alcohol/drug abuse	
Depression	
Anxiety	
Bipolar Disorder	
Schizophrenia	
Eating Disorders	
Suicide Attempts	

Substance Use:

How many drinks of alcohol do you consume per week, on average? _____

Do you have any concerns about your drinking? Y or N

Has anyone else expressed concern about your drinking? Y or N

Have you ever thought that you should cut down on your drinking? Y or N

Have you ever had a drink first thing in the morning to get rid of a hangover? Y or N

Do you take any recreational drugs (non-prescription)? _____

Have you ever used inhalants? Y or N

Is there anything else you would like your therapist to know? _____

_____

Substance History	Frequency	Duration	Date of Last Use
Alcohol			
MDMA (Ecstasy, Molly)			
Cocaine			
Methamphetamine			
Prescription Drugs *(for non-prescription use)*			
Marijuana			
Heroin			
Opioids			
Hallucinogens *(LSD/Mushrooms)*			
Tobacco			
Other			

Wrap Up

Please describe your self-care practices (yoga, meditation, journaling, etc) _____

Is there anything else you would like your therapist to know? _____

_____