INDIVIDUAL COUNSELING APPLICATION

Name: ____ Pronouns: _____________ Age: ________

Address: ____

____

Contact Information	OK to leave messages?	Preferred contact?
Phone:	☐ Yes ☐ No	☐ Yes
Email:	☐ Yes ☐ No	☐ Yes

How long have you lived in Oregon? ____

How were you referred to this office? ____

PARTNER & CHILDREN

If in a primary relationship, name of partner: ____

If living together, how long? ____

Are there children living with you? ☐ Yes ☐ No

Name_________________________ Age_______

Name_________________________ Age_______

Name_________________________ Age_______

Other individuals living with you? ____

LIFESTYLE

Current Employment: ____

Length: _____________________ If not employed, how long? ________________________________

Most Recent Education: ____

Religious or Spiritual Affiliation? ____

Support System: ____

What brought you here today? ____

____

____

BACKGROUND INFORMATION

Are you bothered by any of the following?

- □ Aggression
- □ Wide mood swings
- □ Anxiety
- □ Fatigue
- □ Relationship problems
- □ Body image concern
- □ Overuse of phone/gaming
- □ Loneliness
- □ Nightmares
- □ Obsessive thoughts
- □ Memory difficulty
- □ Loss of pleasure
- □ Guilt/shame
- □ Depression
- □ Compulsive behavior
- □ Stress
- □ Sexual problems
- □ Chronic pain
- □ Sadness
- □ Impulsivity
- □ Alcohol or drug use
- □ Post-partum depression
- □ Low self esteem
- □ Unhealthy eating habits
- □ Issues with fertility
- □ Hopelessness
- □ Thoughts of death
- □ Parenting problems
- □ Sleep problems
- □ Irritability
- □ Self-harm
- □ Panic attacks
- □ Thoughts of harming others
- □ Other:

Are your problems affecting any of the following?

- □ Mental health
- □ Everyday tasks
- □ Self esteem
- □ Recreation
- □ Physical health
- □ Finances
- □ Sexual activity
- □ Housing
- □ Relationships
- □ Future goals
- □ Other:

Have you ever had thoughts, made statements, or attempted to hurt yourself?

Have you ever had thoughts, made statements, or attempted to hurt anyone else?

Have you ever experienced any of the following?

- □ Victim of crime
- □ Discrimination
- □ Physical abuse
- □ Multiple family moves
- □ Serious auto accident
- □ Parental substance abuse
- □ Emotional abuse
- □ Violence in home
- □ Financial hardship
- □ Foster home
- □ Adoption
- □ Life threatening illness
- □ Sexual abuse
- □ Loss of loved one
- □ Neglect
- □ Homelessness
- □ Other:

HEALTH HISTORY

Access to Healthcare: _____________________________ Date of Last Visit: ___________________
Current Health Concerns: ____
Past Health Concerns: ____
Surgeries: ____
Current Treatments: ____

Are you on any psychiatric medication now or in the past? __________________________________
____

Any family members who have been on psychiatric medication, hospitalized or in some other way been treated for mental health issues? ____
____

How is your sleep? (hours per night, quality, difficulty falling asleep or waking)

____
____

Have you ever participated in therapy or counseling before? □ Yes □ No

Dates	**Provider Name**	**Experience positive or negative?**

USE OF SUBSTANCES

Caffeine Intake: ____
Alcohol Use: ____
Cannabis Use: ____
Tobacco Use: ____
Psilocybin Use: ____
Use of Cocaine, Crack, Ecstasy, Heroin, Inhalants, Methamphetamines, Pain killers, PCP/LSD, Steroids, Tranquilizers, or other: ____
____

Are there members of your family or friends who have problems with alcohol or drugs?

____
____

Please describe the changes you would like to see as a result of counseling?

____
____
____
____
____

Is there anything else that you feel is important for me to know?

____
____
____
____
____

____

Client signature   Date