Lisa Wilson, LPC, 5926 NE 32nd Avenue, Portland, OR 97211

Client Information Sheet

Client's name: ____________________________________ Date: _________________

Address: ____

City, State: ____ Zip: ________________

Phone numbers ***with area code*** Home: (   )___________________

Work: (   )_______________   Cell: (   )_________________

Birth date: ________________ Age: ____ Preferred Pronoun: ______________________

Employer: ____

Position: ____ For how long?____________

Education: ____

Marital/relationship status: _____________ Significant other's name: ________________

Significant other's age and sex: __________ How long together? ___________________

Names and ages of all children in the home: _____________________________________

____

Who shall I contact in case of emergency?

Name: ______________________________________Phone (   )____________

In this box, please indicate the address and telephone number you want us to use to when sending bills or when we need to contact you. If this box is left blank, we will use the address and any of the telephone numbers you have provided above.

If you do *not* want us to leave a message on your answering machine, please tell us how you want us to reach you by phone:

I hereby consent for Lisa E. Wilson, LPC to provide evaluation and treatment to me.

____

Signature   Date

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Medical and Health History

Name:____ Date:________________________

List any allergies you have: ____ None_____

Primary Care Physician: __________________________Address:_______________________

City:_____________________________________ State:_____________ ZIP:______________

Primary Care Physician's phone number: (____) ___________________

Date of your most recent physical examination:_____________________________________

Please list all current medications and dosages:

Name of Medication	Dosage	Name of Prescribing Doctor	When did you start taking it?

Please list all current or past health problems, and any major operations:

Current	Past

Have you had therapy before? What was your experience like?

____

____

____

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What kind of problem brings you here today?

____

____

____

____

If you have had this problem before, what has worked in the past for you?

____

____

____

Is there anything you tried before that didn't work?

____

____

____

List any substance abuse treatment or inpatient psychiatric treatment you have had, and the dates: ____

____

Please indicate which of these substances you currently use:

Substance	**Amount used**	**How often?**
Cigarettes		
Alcohol		
Pills not prescribed for me		
Marijuana		
Cocaine or crack		
Psychedelics		
Opiates		
Other (please list):		

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Please indicate if you are having any of the following problems, or if you had them in the past:

	I have this now	I had it in the past
Difficulty falling asleep or staying asleep	______	______
Sleeping too much	______	______
Change in appetite, weight loss, or weight gain	______	______
Frequent crying	______	______
Panic attacks or anxiety attacks	______	______
Thoughts of killing or hurting myself	______	______
Attempts to kill or hurt myself	______	______
Problems concentrating	______	______
Problems remembering things	______	______
Periods of daily sadness lasting more than two weeks	______	______
I startle easily	______	______
Can't stop remembering upsetting past events	______	______
Difficulty controlling my temper	______	______
I physically hurt other people	______	______
I break things sometimes	______	______
I worry a lot	______	______
Little or no interest in sex	______	______
I feel tired almost every day	______	______
Feelings of unreality	______	______
Made myself throw up in order to lose weight	______	______
Used laxatives or exercised excessively to lose weight	______	______
I often feel like I am an outsider	______	______
Sexual problems	______	______
Worry that something is wrong with my body	______	______
Frequent arguments with the people I live with	______	______
I hear voices inside my head	______	______

Other (please list):

____

____

Have you ever thought about suicide, planned a suicide or attempted suicide? Are you currently contemplating suicide? Please describe.

____

____

____

____

____

Signature Date