Kim E. Lucey, LCSW
1020 SW Taylor St. Suite 700
Portland, OR 97205
Phone 971-225-0105 Fax 971-200-0699
kimluceylcsw@gmail.com

Client Name: _____

Today's Date: _____ Referred by:_____

****PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY. IF ANY QUESTIONS ARE NOT CLEAR OR NOT COMFORTABLE, PLEASE FEEL FREE TO LEAVE BLANK AND ASK ANY QUESTIONS.**

CLIENT INFORMATION

Name:

_____

Last First MI Maiden Name

Address:

_____

Street City State Zip Code Email Address

Telephone: _____

Work Home Cell

Birth Date: _____ Age: _____Gender: _____ Preferred Pronoun_____

Education/Training: _____

Employer: _____How Long?_____Occupation_____

Employer's Address:

_____

Street City State Zip Code

Emergency Contact: _____Relationship:_____Phone: _____

INSURANCE INFORMATION

If your insurance requires prior authorization have you obtained it? □ Yes □ No

Authorization Code: _____

Insurance Company: _____Phone: _____

Address: _____

Street City State Zip Code

Policy Holder: _____Birth Date: _____Relationship to client:_____

ID Number: _____Group Number: _____

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Client Name: _____

Client or authorized person's signature (Required): I authorize the release of any medical or other information necessary to process claim. I authorize payment of medical benefits to the provider of services. I accept responsibility for paying any amount not covered by insurance.

Signed:
_____Date:_____

RELATIONSHIP INFORMATION

Relationship status: □ Single □ Married □ Divorced □ Separated □ Widowed □ Domestic Partnership/Civil Union □ Dating □Partnered □Other

Sexual Orientation: □ Heterosexual/Straight □ Gay □ Lesbian □ Bisexual □ Queer □ Questioning

Name of Spouse/Partner if applicable: _____Length of Relationship:_____

Partner's Birth Date: _____ Age: _____ Gender: _____Telephone Number: _____

Please list the names of your children, step-children or other significant others in your life (Please include names, ages, and whether they live with you):

_____
_____
_____
_____
_____

Relationship Strengths or Values:

_____
_____
_____

Describe any relationship or family stressors:

_____
_____
_____

What are your greatest strengths?_____
_____
_____

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TREATMENT HISTORY

Have you ever been in counseling before? □ Yes □ No

Dates	Name of Counselor	Phone Number/Ok to contact?
Dates	Name of Counselor	Phone Number/Ok to contact?
Dates	Name of Counselor	Phone Number/Ok to contact?

What has been helpful in counseling in the past?

_____

What has not been helpful in counseling in the past?

_____

PRESENTING CONCERNS

Describe the concerns/symptoms that have brought you here today:

_____
_____
_____
_____

SYMPTOMS

(Check any symptoms that you are having or have had recently, star the five that are most intense for you)

□ Feeling hopeless
□ Extreme happiness
□ Lack of enjoyment of usual activities
□ Feeling on edge
□ Fear of situations where escape is hard
□ Change in sleeping habits
□ Paranoid thoughts
□ Indecisiveness
□ Extreme sadness
□ Feeling stressed
□ Easily irritated
□ Feeling guilty
□ Feeling fearful
□ Trouble at work
□ Procrastination
□ Mind going blank
□ Depression
□ Low self-esteem
□ Excessive worry
□ Feeling anxious
□ Sudden feelings of panic
□ Self-starvation
□ Reckless behavior
□ Hearing voices

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□ Increased use of alcohol or drugs	□ Avoiding things	□ Crying spells
□ Thoughts about hurting yourself	□ Thoughts about killing yourself	□ Suicide attempts
□ Thoughts about hurting others	□ Thoughts about killing others	□ Acted violently
□ Problems with anger	□ Intrusive thoughts	□ Relationship struggles
□ Physical complaints of pain	□ Chest pain	□ Chronic pain
□ Memory problems	□ Trouble concentrating	□ Low energy
□ Numbness	□ Dry mouth	□ Appetite changes
□ Weight changes	□ Stomach or bowel issues	□ Chronic Weakness
□ Nerve problems	□ Exaggerated startle response	□ Trembling
□ Twitching	□ Muscle tension/aches	□ Shortness of breath
□ Heart symptoms	□ Hot flashes	□ Frequent urination
□ Change in sexual function	□ Change in sexual function	□ Gender issues

□ Others not listed: _____

Have you ever been hurt (physically or sexually) by someone you are close to or involved with, or by a stranger? □ Yes □ NO

Are you currently being hurt by someone you are close to or involved with? □ Yes □ No

Do you feel safe at home? □ Yes □ No

GOALS FOR TREATMENT

What are you main goals for treatment? How would you feel successful?

1._____

2._____

3._____

MEDICAL INFORMATION

Do you have any current medical struggles? □ Yes □ No (If yes, please describe)

_____

_____

_____

_____

Do you have any allergies (prescriptions meds, over the counter, other things? □ Yes □ No

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Client Name: _____

If yes, what are you allergic to and what is your reaction?

_____

Who is your Primary Care Doctor? _____Phone: _____

Have you seen a doctor in the past year? □ Yes □ No

Name: Phone: Reason for visit: Diagnosis: Outcome:

_____
_____
_____

Are you taking any medication (Prescription, over the counter or herbal)? □ Yes □ No

(Please list)

Medication: Purpose: Dosage: Start Date: Prescriber:

_____
_____
_____
_____

Have you ever been hospitalized? □ Yes □ No

For what reason?_____

Location/facility name: _____

Has anyone in your family had similar emotional or psychological difficulties or concerns? Please explain.

_____
_____
_____

SUBSTANCE USE HISTORY

Have you ever use tobacco in any form? □ Yes □No

(Please describe history, age of first/last use and current pattern of use)

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Client Name: _____

_____
_____
_____

Have you ever used alcohol? □Yes □ No

(Please describe history, age of first/last use and current pattern of use)

_____
_____
_____

Have you ever used illegal drugs? □ Yes □ No

(Please describe history, age of first/last use and current pattern of use)

_____
_____
_____

Have you ever received treatment for substance abuse/use? □ Yes □ No

Date: Where: Did you complete? Counselors name/phone/may I contact?:

_____
_____
_____

Please describe any family history of substance use/abuse:

_____
_____
_____

LEGAL

(Please check all that apply)

□ No legal problems □Parole/probation □ Arrest (s) not substance related

□ Arrest (s) substance related □Jail/Prison time

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Client Name: _____

Last legal difficulty (when and what was nature): _____

CULTURAL AND RELIGIOUS/SPIRITUAL PRACTICE

How would you describe your race or ethnicity?

_____

Religion/spiritual history: _____

Importance of spirituality/religion: □ Low □ Medium □ High

Please describe cultural and spiritual/religious activities or traditions that are important to you:

_____

_____

Are you currently active in your community in other areas? □Yes □ No

Please describe: _____

FINANCIAL, LIVING AND SUPPORTS:

Living (please check all that apply):

□ Adequate housing □ Homeless □ Housing overcrowded

□ Dependent on others for home □ Housing dangerous/deteriorating

□ Living companions unstable

Employment (please check all that apply):

□ Employed and satisfied □ Employed but dissatisfied □ Unemployed

□ Conflicts at work □ Unstable work history □ Disabled

Military (please check all that apply):

□ Never in the military

□ Served with no incident

□ Served with incident

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Client Name: _____

Please describe:

_____

Financial Situation:

□ No current financial stress □ Large Debt □ Low Income

□ Impulse spending □Relationship conflict over money

Social Supports:

□ Supportive network of friends and/or family □ A few friends □ New to the area

□ No friends □ Geographically or emotionally distant from family