

Kim E. Lucey, LCSW
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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?
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Dates	Name of Counselor	Phone Number/Ok to contact?
-------	-------------------	-----------------------------

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

- | | | |
|--|---|---|
| <input type="checkbox"/> Feeling hopeless | <input type="checkbox"/> Extreme sadness | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Extreme happiness | <input type="checkbox"/> Feeling stressed | <input type="checkbox"/> Low self-esteem |
| <input type="checkbox"/> Lack of enjoyment of usual activities | <input type="checkbox"/> Easily irritated | <input type="checkbox"/> Excessive worry |
| <input type="checkbox"/> Feeling on edge | <input type="checkbox"/> Feeling guilty | <input type="checkbox"/> Feeling anxious |
| <input type="checkbox"/> Fear of situations where escape is hard | <input type="checkbox"/> Feeling fearful | <input type="checkbox"/> Sudden feelings of panic |
| <input type="checkbox"/> Change in sleeping habits | <input type="checkbox"/> Trouble at work | <input type="checkbox"/> Self-starvation |
| <input type="checkbox"/> Paranoid thoughts | <input type="checkbox"/> Procrastination | <input type="checkbox"/> Reckless behavior |
| <input type="checkbox"/> Indecisiveness | <input type="checkbox"/> Mind going blank | <input type="checkbox"/> Hearing voices |
| <input type="checkbox"/> Increased use of alcohol or drugs | <input type="checkbox"/> Avoiding things | <input type="checkbox"/> Crying spells |

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- | | | |
|--|--|---|
| <input type="checkbox"/> Thoughts about hurting yourself | <input type="checkbox"/> Thoughts about killing yourself | <input type="checkbox"/> Suicide attempts |
| <input type="checkbox"/> Thoughts about hurting others | <input type="checkbox"/> Thoughts about killing others | <input type="checkbox"/> Acted violently |
| <input type="checkbox"/> Problems with anger | <input type="checkbox"/> Intrusive thoughts | <input type="checkbox"/> Relationship struggles |
| <input type="checkbox"/> Physical complaints of pain | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Chronic pain |
| <input type="checkbox"/> Memory problems | <input type="checkbox"/> Trouble concentrating | <input type="checkbox"/> Low energy |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Appetite changes |
| <input type="checkbox"/> Weight changes | <input type="checkbox"/> Stomach or bowel issues | <input type="checkbox"/> Chronic Weakness |
| <input type="checkbox"/> Nerve problems | <input type="checkbox"/> Exaggerated startle response | <input type="checkbox"/> Trembling |
| <input type="checkbox"/> Twitching | <input type="checkbox"/> Muscle tension/aches | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Heart symptoms | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Change in sexual function | <input type="checkbox"/> Change in sexual function | <input type="checkbox"/> Gender issues |
| <input type="checkbox"/> 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 your 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

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

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Client Name: _____

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)

Have you ever used alcohol? 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 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

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

CULTURAL AND RELIGIOUS/SPIRITUAL PRACTICE

How would you describe your race or ethnicity?

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Client Name: _____

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

Please describe:

Financial Situation:

- No current financial stress Large Debt Low Income
- Impulse spending Relationship conflict over money

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Social Supports:

- Supportive network of friends and/or family A few friends New to the area
 No friends Geographically or emotionally distant from family