Wendy Curtis, MA, LPC
Live Grow Transform
2929 SW Multnomah Blvd., Suite 210
Portland, OR 97219

INTAKE FORM

In order to best serve you, it is helpful for me to have some background information. Your cooperation in completing this questionnaire will enable me to be more effective, and will make the time we work together more productive. Please answer the questions as accurately and completely as you can. This information is strictly confidential.

Full Legal Name _____ Preferred First Name _____

Date of Birth_____ Gender _____ Today's Date _____

Full Address_____

_____

Home Phone _____ May I leave a message? Yes / No

Cell Phone _____ May I leave a message? Yes / No

Work Phone _____ May I leave a message? Yes / No

Please place an asterisk (*) by your preferred phone.

How did you find me? ❑ Online search ❑ Personal referral

Referred by_____ May I thank them for the referral? Yes / No

Have you had any previous Therapy/Counseling? Yes / No If yes, when_____

How long_____ What for_____

Was it helpful/not helpful? Please describe _____

_____

Physical History

Describe your general health _____

Any recurrent or chronic medical or mental conditions_____

_____

The last time you saw a doctor _____

Any medications currently being taken_____

Work History

Occupation _____ How long?_____

If presently unemployed, describe the situation _____

Hobbies/Avocations _____

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Family Systems Information

Father alive _____ If deceased, what year? _____ Cause of death_____ If alive, where residing _____ Relationship closeness currently_____

Mother alive _____ If deceased, what year? _____ Cause of death_____ If alive, where residing _____ Relationship closeness currently_____

Parents divorced?_____ If yes, what year _____ Your age at the time_____

Any step parents?_____ If yes, describe your relationship with them _____

_____

If raised by someone other than your birth parents, describe the situation _____

_____

Please write anything else that you think would be helpful for me, as your therapist, to know about your family of origin dynamics _____

_____

_____

Your Siblings

#1 Name _____ Male / Female Age ____ Relationship closeness _____

#2 Name _____ Male / Female Age ____ Relationship closeness _____

#3 Name _____ Male / Female Age ____ Relationship closeness _____

#4 Name _____ Male / Female Age ____ Relationship closeness _____

#5 Name _____ Male / Female Age ____ Relationship closeness _____

Family Alcoholism/Drug Addiction? Yes / No Members _____

Family Domestic Violence? Yes / No Abusive members_____

Your marital status _____ # of marriages ____ Spouse's name _____

Living with a partner _____ How long _____ Partner's name _____

Your Children

#1 Name_____ Male / Female Age ____ Lives with you Yes / No

#2 Name_____ Male / Female Age ____ Lives with you Yes / No

#3 Name_____ Male / Female Age ____ Lives with you Yes / No

#4 Name_____ Male / Female Age ____ Lives with you Yes / No

#5 Name_____ Male / Female Age ____ Lives with you Yes / No

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Chemical Substances Use

Think about any and all chemicals substances (such as caffeine, nicotine, alcohol, THC, prescription painkillers, etc.) you have used, and indicate how often. Please answer these questions fully, even if it does not seem to apply to your mental health. It is not my intention to pass judgment; it is just good information for me to have in order to have a fuller picture of how you are doing. Please note: Do not count use of chemical substances to treat an illness; instead, report times you used substances to get high or feel better. This can include both prescription and non-prescribed substances.

Chemical Substance	Age at 1st use	Last Used	How often used in past 30 days (X times per week, X times a day)
Caffeine			
Nicotine/tobacco (smoked or chewed)			
Alcohol (beer, wine, hard liquor, etc.)			
Marijuana/THC			
Cocaine/crack/crystal meth/speed/etc.			
Inhalants/"huffing"			
LSD, acid, other hallucinogens			
Prescription painkillers such as codeine, Vicodin, etc.			
Over the counter medication such as cough syrup, Nyquil, etc.			

Have you ever had any of the following in connection with your chemical substance use:

O Withdrawal symptoms O Blackouts O Cravings O Overdoses O Hospitalization O Tolerance

O Preoccupation O Failed attempts to cut back or control use O Other problem: _____

How would you describe yourself in terms of chemical substance use?

In terms of alcohol use:

O I am a social drinker O I sometimes worry about my drinking O I have a drinking problem O I am a heavy drinker O I have alcoholism O Other: _____

In terms of drug use:

O I am a recreational drug user O I sometimes worry about my drug use O I have a drug problem

O I have an addiction O Other: _____

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Spiritual History

Religious upbringing _____ Present affiliation _____

Is this an important part of your life?_____ Why/why not_____

Emotional Status

Are you currently experiencing strong emotions? _____ If yes, please describe _____

_____

Do you make decisions based on your emotions?_____ How well does that work for you?

_____

Did you have what you would consider to be childhood or other traumas? _____ If yes, please describe _____

Have you had any thoughts of suicide?_____ If so, when_____ Do you have any thoughts now?_____

Present Situation

Please share why you decided to come in for therapy at this time _____

_____

What is the nature of your situation? _____

_____

How long has this been a problem for you? _____

What would you like to get out of therapy, work on, or experience differently than what you are experiencing now? _____

_____

_____

Is there anything else that would be helpful for me to know about you, or your life, in order to best know who you are? Please write as much as you need to below and on the back of this page: