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Fifth Street Public Market
296 Fifth Avenue. Suite 311
Eugene, Oregon, 97401

Client Information:

Name: _____

Birth Date: _____ /_____ /_____ Age: _____ Gender:_____

Address: _____

Home Phone: _____Cell/Phone:_____

May I leave a voice message? Yes_____No _____

May I leave a text message? Yes_____No_____

E-mail: _____ May I email you? Yes_____ No_____
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by : _____

May I contact this person? _____

Areas of concern that bring you to therapy:_____

_____

_____

_____

Primary goal(s) of therapy:_____

_____

_____

What has helped you in the past:_____

_____

_____

RELATIONSHIPS:

Your Relationship Status:

Never Married_____ Domestic Partnership_____ Married_____ Separated/Divorced_____
Widowed_____ How many years?_____

On a scale of 1-10, how would you rate your relationship? _____

If you have children, list gender & ages, and/or others present in your household:

_____

_____

Relationship Concerns:_____

_____

_____

PHYSICAL AND MENTAL HEALTH INFORMATION:

Name and phone number of current PCP:_____

Rate your current physical health (please circle):

Poor Unsatisfactory Satisfactory Good Very good

List any specific health problems you are currently experiencing_____

_____

_____

_____

Are you currently experiencing any chronic pain? No_____ If yes, please describe:_____

_____

How often do you exercise? _____

What types of exercise do you participate in: _____

Are you currently experiencing any of the following symptoms? (please circle):

Anxiety	Sadness/Grief	Weight Gain/Weight Loss
Panic	Depression	Anger
Loss of Appetite	Sleep Complaints	Eating Disorders
Social Withdrawal	Poor Concentration	Other:
Obsessions/Compulsions	Memory Difficulties	

Have you previously received any type of mental health services (psychotherapy, couples counseling, psychiatric services, etc.)? Yes _____ No_____

If yes, please provide previous therapist name and approximate dates:

_____

Previous psychiatric hospitalizations: _____

Current prescription mental health medication (and name of prescriber):_____

_____

_____

Current natural or alternative meds, supplements or mental health treatments:

_____ _____

If you drink alcohol, how much and how many times per week:_____

_____

If you use recreational drugs, how often and what types of drugs:_____

_____

Have you had any inpatient or outpatient treatment for alcohol or drug use?

_____

FAMILY MENTAL HEALTH HISTORY:
In the section below, please identify if there is a family history of any of the following and indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Alcohol/Substance Abuse Anxiety
Depression
Domestic Violence
Eating Disorders
Obsessive Compulsive Behavior
Other Mental Diagnosis_____ Suicide Attempts_____

List FamilyMember(s)_____

ADDITIONAL INFORMATION:

Are you currently employed?_____

Do you enjoy your work? Is there particular stress in your current work? _____

_____

Highest level of education:_____

Do you consider yourself spiritual or religious? If yes, describe your spirituality, faith or belief:

_____

_____

What do you like most about yourself or consider to be your best attributes?

_____

_____

Are there any concerns about self esteem or anything about yourself you do not like?

_____

_____

Is there anything, not covered above, you would like me to know?_____

_____

_____

I understand that completion of the above is for informational purposes and it does not constitute a contract for services.
I agree to pay for sessions at the time of the appointment. If insurance is being utilized, I agree that it is my responsibility to understand my coverage, co-pays and deductibles. The billing of insurance by the provider is a courtesy and I am ultimately responsible for payment of services provided. The information on this form is considered confidential.

Name:_____

Date:_____