Anne M. Cuthbert, M.A., Licensed Professional Counselor
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Client Information

Name _____ Date of Birth _____

Address _____ Age _____

Email _____ Home Phone _____

Work Phone _____

Occupation _____ Cell Phone _____

Employer _____ Other Phone _____

Physician _____

Emergency Contact _____

Marital Status _____

Spouse/Partner Name _____

Number in Home _____

Children Names _____ Ages _____

_____ _____

_____ _____

_____ _____

Are you currently taking any medication? _____

If so, what type? _____

Have you had any difficulties in the last 6 months with the following?

		If so, please explain:
Sleeping	_____	_____
Eating	_____	_____
Memory	_____	_____
Concentration	_____	_____
Anger	_____	_____
Aggressive Behavior	_____	_____
Anxiety	_____	_____
Panic	_____	_____
Social Relationships	_____	_____
School Functioning	_____	_____
Work Functioning	_____	_____
Obsessive Behavior	_____	_____
Guilt	_____	_____
Crying	_____	_____
Apathy	_____	_____
Avoidance	_____	_____
Sexual Dysfunction	_____	_____
Physical Complaints	_____	_____

Client Info Page 2

Name _____

Do you use:

	Y/N	How Much/How Often?
Alcohol		
Cigarettes		
Other Drugs		

Has anyone ever told you that you have a problem with alcohol or drugs? _____

Have you ever tried to quit any of the above? _____

If so, what happened? _____

Have you been hospitalized in the past 5 years? _____

If so, please describe: _____

_____

Have you ever thought of hurting yourself? _____

Have you ever thought of hurting someone else? _____

Is there other information that is relevant to this assessment? _____

_____

_____

_____

_____

_____

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_____

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