Cynthia J. Aerni, M.S., LPC
2929 SW Multnomah Blvd.
Suite 203A
Portland, Oregon 97219
(503) 899-2296

This form asks you to provide information about your current life, some medical history, your family background, and your goals for counseling. Information you provide on this form will be kept confidential. It will help me to understand the family you grew up in, the family you are in now, and your most current concerns so that we can direct our attention to areas of growth that are important to you at this time.

Name:_____Date:_____

Gender: Male____ Female____ Age_____Date of birth:_____

Home Address_____

City/State/Zip_____

Primary phone #_____Cell☐ Work☐ Home☐ ☐ Check if okay to leave message

Alternate phone #_____Cell☐Work☐ Home_☐ ☐ Check if okay to leave message

Email_____ ☐ Check if okay to send a message

Occupation_____Place of employment_____

Name Relationship Phone

Emergency Contact: _____

(This is someone who would be contacted in an emergency, possibly without your written permission)

How did you find me?

- ☐ Internet
- ☐ Referred by a friend
- ☐ Brochure
- ☐ Other_____

RELATIONSHIP

Current relationship status:

- Single
- In partnership, unmarried
- Married
- Separated. How long?_____
- Widowed. How long?_____
- Divorced. How long?_____Number of times?_____

How long have you been with your current partner? _____ Are you currently living together?_____

CHILDREN

Names of Children: Biological or Step, Gender, and Age(s). Please indicate whether child is currently residing in your home full time (FT) or part time, (PT) or not at this time (NATT):

Name/s	Biological/Step	Gender	Age	FT/PT/NATT?

PHYSICAL AND MENTAL HEALTH

Physician name_____Phone_____

Are you currently receiving medical treatment? ☐ Yes ☐ No

If yes, please explain_____

Are you currently taking any prescription medications? ☐ Yes ☐ No

If yes:

Medication	Dosage	Reason for use

Please use other side if page in you need more room.

How often to you use alcohol or other drugs?

- Never
- Less than once per month
- 1-5 times per week
- Daily

If yes, what and how much?_____

Do you smoke cigarettes? ☐Yes ☐No

If so how many per day?_____

Has alcohol or drug use caused problems in your life? ☐ Past ☐ Present ☐ Never

Do you exercise? ☐Yes ☐No

If so, what form of exercise and how often?_____

Do you get enough sleep? ☐Yes ☐No

Are you happy with your eating habits? ☐Yes ☐No

Have you experienced a change in eating, sleeping routines or weight in the last 2-3 months?

If so, please explain_____

Are you **currently** experiencing any of the following? (Please check all that apply)

☐ Thoughts or plans to harm yourself ☐ Domestic Violence

☐Thoughts or plans to harm other(s)

If you are not currently experiencing any of these feelings, have you **in the past**? ☐Yes ☐No

If yes, please briefly describe the circumstance_____

_____

Have you or anyone you know ever attempted suicide? ☐Yes ☐No

If yes, whom and when?_____

Have you ever had a mental health diagnosis? ☐Yes ☐No

If yes, what was the diagnosis?_____

When was the diagnosis?_____

Your CURRENT concerns: *(Please check all that apply)*

- Health concerns
- Parenting
- Loneliness
- Separation/Divorce
- Worthlessness
- Hopelessness
- Obsessive thoughts
- Financial difficulties
- Manic behavior
- Compulsive behavior
- Anxiety
- Sexual concerns/difficulties
- Career/Job
- Phobias
- Relationship troubles
- Anger issues
- Panic attacks
- Low self-esteem
- Poor concentration
- Loss of interest in activities
- Mood swings
- Sleep difficulties
- Withdrawn
- Shame

Other concerns not listed above_____

Please indicate on the scale below, how distressing your problems are to you currently:

_____

Very little distress *Neutral* *Extremely distressed*

FAMILY OF ORIGIN

Before you were 18, did you experience any of the following:

- Raised by someone other than your biological parent. Who? _____
- Parents divorced (your age_____)
- Adopted (your age____)
- Lived with a step-parent (your age____)
- Lived with step-siblings (your age____)
- Other _____

Did either of your parents abuse alcohol and/or drugs when you were growing up? ☐ Yes ☐ No

Brothers and Sisters: Name Age

_____

_____

_____

_____

Please use the other side if you need more room

Have you experienced the death of someone close to you? Who? _____When? _____

When I was a child my feelings about my family were: _____

_____

My feelings about my family now are: _____

Have you been to counseling before? _____ With whom?_____

When?_____Did you find it helpful? _____

If yes, what was most helpful to you?_____

YOUR GOALS

What do you hope to gain or change in counseling? _____

What prompted you to seek counseling at this time? _____

_____

What is the best part of your current life?_____

What is the most difficult part? _____

What do you do for fun?_____

What do you do to relax?_____

What do you consider to be your greatest strengths? _____

Please add anything else that you would like me to know. _____

_____

Signature_____