SEASONS OF HOPE
INC.
A COMPANY OF CHANGING SEASONS COUNSELING, INC.
Laina M. Winters, MSW, LCSW

503-314-8598

Client/Couple's Information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone numbers Home: _____ Cell: _____ Work: _____

May we leave messages for you at ____home ____cell ____work (check if yes for each location)

E-mail address: _____ Can we send you E-mails? Yes / No (circle one)

Age: _____ Date of Birth: _____ Place of employment: _____

Emergency Contact Information: _____

Marital Status:

____ Single ____ Married ____ Partnered ____ Divorced ____ Separated ____ Widowed

Partners Information (If applicable)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone numbers Home: _____ Cell: _____ Work: _____

May we leave messages for you at ____home ____cell ____work (check if yes for each location)

E-mail address: _____ Can we send you E-mails? Yes / No (circle one)

Age: _____ Date of Birth: _____ Place of employment: _____

Children:

Name _____ Age _____

_____ _____

_____ _____

_____ _____

Presenting concerns

Primary reason for seeking counseling services:

Check any symptoms that you are experiencing:

Depressed mood/feeling hopeless		Extreme sadness		Difficulty Concentrating/ Easily distracted	
Tearful		Lack of energy/fatigue		Impulsiveness	
Elevated mood		Difficulties performing at work		Lack of enjoyment	
Experiencing low self-esteem		Perfectionism		Obsessive/Compulsions	
Feeling fearful		Physical complaints of pain		Anger management issues	
Thoughts of self harm		Thoughts of harming others		Change in sleep habits	
Weight changes (gain/loss)		Change in eating habits		Memory impairment	
Change in sexual interest or function		Difficulties with personal or professional relationships		Feeling stressed	
Easily irritated		Feelings of Guilt/shame		Feeling anxious/nervous	
Sudden feelings of panic		Muscle tension		Violent behaviors	
Experiencing auditory Hallucinations		Experiencing visual hallucinations		Addictive behaviors	
Experienced a recent death/loss		Complications associated with pregnancy/conceiving		Experiencing Domestic Violence	
Excessive worrying		Social anxiety		Speech problems	
Loneliness		Mood swings		Nightmares	
Ulcers		Headaches		Other	

Counseling History

Have you ever been in counseling before? ____ Yes ____No

Have you ever had a psychological evaluation? ____ Yes ____No

If yes, with whom? _____

How long were you in counseling?_____

Have you ever been prescribed any psychiatric medications? ____ Yes ____No

If yes, what medications? _____

What was the outcome of your counseling experience? _____

_____

Medical History

Primary Care Physician:_____ Phone Number: _____

Have you seen your PCP within the last year? ____ Yes ____ No

If yes ____ Routine visit ____ Other (please explain) _____

_____

Are you currently taking any prescription or over the counter medications? ____ Yes ____ No

If yes, what? _____

If you are female, have you ever been pregnant? ____ Yes ____ No

If yes, where there any complications that you feel are important to be addressed during the course of counseling? ____ Yes ____ No ____ Unsure

Have you been experiencing any irregularity or unusual pain in your menstrual cycle?

____ Yes ____ No If yes, describe? _____

Do you have any allergies? ____ Yes ____ No If yes, what allergies and medications taken?

_____

Developmental History

Are there special, unusual, or traumatic circumstances that affected your development?

____Yes ____ No If yes, describe? _____

Has there been history of child abuse? ____ Yes ____ No

If yes, which type(s)? ____ Sexual ____ Physical ____Verbal ____ Domestic violence

If yes, the abuse was as a: ____Victim ____ Perpetrator

Other issues that impacted your childhood: ____ Neglect ____ Inadequate nutrition ____ other (please specify): _____

Additional information related to your childhood development: _____

Substance use History

Do you use or have you used tobacco (any form)? ____ Current ____ Past _____No

Do you use or have you used alcohol? ____ Current ____ Past _____No

If yes, How often? _____, How much? _____

Do you use or have you used caffeine (any form, including cola drinks)?

____ Current ____ Past _____No

Do you use or have you used recreational drugs? ____ Current ____ Past _____No

If currently yes, How often? _____, How much? _____

Has your use of substances created a problem for you at ____ home, ____ work/school, ____ in your personal relationships.

If so, please explain further _____