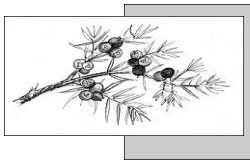

JUNIPER MOUNTAIN COUNSELING

334 NE Irving Ave. Suite 102 ~ Bend, OR. 97701 ~ General and FAX: (541)-617-0377

CLIENT INTAKE FORM

**Note: You may choose to omit any item on this form and instead discuss it with your counselor.*

Date: _____ Name: _____ SSN _____ DOB: _____

Address: _____ Zip: _____

Ph: (H) _____ (Cell) _____ (Wk.) _____

May I leave a message on any of these phones? _____. Which one (s) ? Please circle: H Cell Wk

Referral source: _____.

Please list other people residing in your household.

Name	Relation	Age/ Grade

WHAT ARE YOUR REASONS FOR SEEKING COUNSELING AT THIS TIME? _____

_____

_____

_____

HAVE YOU BEEN IN INDIVIDUAL OR GROUP COUNSELING IN THE PAST? _____. If so, which one? Ind. Grp.

If so, please explain: _____

_____

_____

_____

WHO WAS YOUR COUNSELOR AT THAT TIME? _____.

Are you, or have you been working with other professionals (psychiatrists, psychologists, counselors, doctors, etc…) with whom it would be beneficial for me to speak, in order to more effectively develop a counseling plan? If so, please list:

_____

_____

_____

_____

**Note: I will ask you to sign a Release of Information Form prior to communicating with any of the parties listed above.*

Please list past or recent life events, transitions, losses, role changes, etc., which it would be helpful for me to be aware of:

_____

_____

_____

_____

Please *circle* any of the following which are (or have been) present in you OR your family and briefly explain below:

Depression Anxiety Panic Attacks PTSD (Post Traumatic Stress Disorder) Traumatic Events

Emotional Problems Bi Polar Disorder Schizophrenia Alcohol or Drug abuse/ Addiction Other Addictions

Other mood / personality disorders Sexual or Physical Abuse Chronic Illness

_____

_____

_____

_____

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MEDICAL Information (Note: I will ask you to sign a Release of Information Form prior to speaking with your doctor, unless you have been referred by Mosaic Medical. If so, you have already agreed to allow this contact within their orientation materials.)

Doctor: _____. Date last seen: _____.

Where is your doctor located? _____.

Any current medical problems or medications? Specify: _____

_____.

Medications are to treat which symptoms? _____

_____.

Please list any past illnesses and major injuries which would be helpful for me to be aware of:

WHAT ARE YOUR FAVORITE HOBBIES OR ACTIVITIES?

PLEASE ADD ANY OTHER INFORMATION YOU FEEL WOULD BE HELPFUL FOR ME TO KNOW:

Client Signature: _____*Date:* _____

JMC Counselor signature _____ *Date:* _____

Thank You!
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