Community Counseling Center of Ashland LLC
600 Siskiyou Blvd., Ashland, OR 97520
www.CCCofAshland.com • 541-708-5436

Client Confidential Intake Information Form Date_____

Name: _____ Age: _____
Last First
Date of Birth: _____ Place of birth: _____

Street Address: _____ City: _____ State: _____

Zip: _____ email address: _____

Please check box if you would like to receive email notices about Counseling Center events, groups, or news. ☐

Telephone Number: Home: _____ Cell: _____
Work: _____ Other: _____

Gender: Female ____ Male ____ Non-conforming ____
Sexual Orientation: Heterosexual ____ Gay/Lesbian ____ Bisexual ____ Other: _____

Please check box if gender issues are important to you. ☐

Relationship Status: Single ____ Living with partner ____ Married ____ Never married ____
Divorced ____ Separated ____ Widowed ____ If partnered, partner's name:_____

Length of time with current partner:_____ If married, how long?_____
Previous marriages/long-term significant relationships: (how long and how they ended)

_____
_____

Names and ages of children: _____ _____
_____ _____ _____
Living situation of children and any stepchildren: (with you, with other parent, in foster care, or other)

_____
_____

Family of Origin: Is mother living? ___ Yes ___ No Is father living? ___ Yes ___ No
Parents are/were: ___ Married to each other ___ Never married
___ Divorced Your age at time of divorce or separation: _____
Any stepparents? ___ Yes ___ No Stepsiblings? ___ Yes ___ No
Your birth order: # _____ of _____ children
Please list any significant facts of your childhood (adopted, premature birth, significant illnesses, etc.)

_____

Cultural identification: _____

Employer/School: _____ Occupation: _____
Education/Training: (highest level obtained and what specialty) _____
Military Service: ___ Yes ___ No Served in Combat?: ___ Yes ___No
If yes, dates and country/countries _____

Religious identification, if any: _____
Previous experience with therapy? ___ Yes ___ No Spiritual or Pastoral Counseling? ___Yes ___No
Please describe what brings you in to counseling today: _____

_____
_____

On a scale of 1 to 10 where 10 is good, please rate your current experience with:
Sleep_____ diet_____ exercise_____ sexuality_____ job satisfaction_____
relationship w/others_____ relationship with yourself_____ freedom from the past_____ enjoyment of life_____
spiritual life_____ sense of meaning and purpose _____

In the following list, please put a check in the first column if you've experienced that issue in the past, and/or in the second column if you are experiencing it currently:

	Past	Current		P	C
Depression	___	___	Loss of energy or motivation	___	___
Loss of interest in usual activities	___	___	Thoughts of suicide	___	___
Suicide attempts	___	___	Other self-harming behavior	___	___
Thoughts of hurting others	___	___	Unusual irritability	___	___
Anger or explosive behavior	___	___	Racing thoughts/mania	___	___
Anxiety/fearfulness/worry	___	___	Panic attacks	___	___
Need to avoid people in general	___	___	Need to avoid public places	___	___
Nightmares	___	___	Reliving traumatic event	___	___
Taking medications	___	___	Hospitalization for mental health	___	___
Addictions treatment	___	___	Physical abuse	___	___
Sexual abuse	___	___	Rape/sexual assault	___	___
Other trauma	___	___	Other victimization	___	___
Divorce	___	___	Custody issues	___	___
Grieving the loss of a loved one	___	___	Marital or family conflict	___	___
Parent/child conflict	___	___	Communication problems	___	___
Estranged from family	___	___	Loneliness/low self-esteem	___	___
Difficulties at work or school	___	___	Hyperactivity	___	___
Involvement with legal system	___	___	Financial problems	___	___
Medical problems	___	___	Sleep problems	___	___
Sexual problems/concerns	___	___	Memory problems	___	___
Eating disorder	___	___	Hallucinations	___	___
Delusions (false beliefs)	___	___	Unusual thoughts	___	___
Paranoid thoughts or feelings	___	___	Compulsive or repetitive acts	___	___
Obsessive thoughts	___	___	Gambling	___	___
Heavy alcohol use	___	___	Frequent marijuana use	___	___
Prescription drug abuse	___	___	Internet overuse (such as gaming)	___	___
Internet porn or sex	___	___	Loss of appetite/weight loss	___	___
Substantial weight gain	___	___	Binge eating	___	___
Binging and purging	___	___	Anorexia	___	___
Other body image distress	___	___	Victim of a crime	___	___
Major car or bike accident	___	___	Aging issues	___	___
Violence towards/abuse of others	___	___	Loss of time	___	___

Primary physician's name: _____ Tel. # _____

Secondary physician _____ Specialty_____ Tel. # _____

Insurance info (if covered): Insurance Co _____

Auth. # _____ SS# _____Deductible _____ Copay _____

Medication	Prescribed for	Name & Number of Prescribing Doctor

Emergency contact: Name: _____ Tel. # _____

Relationship to you: _____