Jon Fox, MS, LPC
4531 SE Belmont St., Suite 318
Portland, Oregon 97215
(503) 954-4852
www.mindfulnesstherapyportland.com

CLIENT INFORMATION FORM

Name: _____ **Today's Date:** _____

Address: _____

Email: _____

Telephone: (cell) _____ **OK to leave message? Yes ___ No___**

Telephone: (home/work)_____ **OK to leave message? Yes ___ No___**

Date of Birth: _____ **Age:** _____ **Gender:** _____

Occupation: _____ **Education:** _____

Relationship Status:

Single____ Partnered____Married____Divorced____Widowed____

Name and number of person I can contact in case of emergency:

_____

Please list the current members of your household:

Name	Age	Relationship to You

If you have had previous counseling or therapy, briefly describe this experience (when, with whom, and why you sought help):

_____

_____

_____

_____

_____

Briefly describe your reason(s) for seeking counseling:

_____

_____

_____

_____

_____

_____

What do you hope to gain from counseling?:

_____

_____

_____

_____

_____

Any history of trauma? (sexual, physical, emotional abuse, neglect, accidents, surgeries, etc):

_____

_____

_____

_____

_____

Please list any medical problems or physical symptoms:

_____

_____

_____

Primary Care Physician: Name: _____

Address: _____

Phone: _____

Please list any current prescription medication you are taking:

Name of medication:	**Dose :**	**Taken for:**	**Prescribed by:**

Do you currently use alcohol or any illegal drugs/substances? (Please include frequency and amount of daily/weekly use):

_____

_____

_____

_____

Have you thought about hurting or killing yourself within the past 6 months?

No___Yes___

Have you ever attempted suicide? No___ Yes___ If Yes, when?

_____

_____

Who suggested that you contact me for services? _____

May I contact this person or agency to acknowledge the referral?

No ____ Yes ____