

Date:

**A PLACE TO TALK: Counseling and Mediation Services by Ruth Parvin, Ph.D.**  
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**Intake Form**

**Before you come for your first appointment, please take time to fill out those portions of this form that you feel comfortable sharing. Leave blank any questions you do not want or know how to answer. The more information you can provide, the quicker I will be able to get a clear idea of the issues we will work on together. Please use additional paper if you need it. Please bring this form with you to your first appointment.**

Your name: \_\_\_\_\_ Email: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (B) \_\_\_\_\_ (Cell) \_\_\_\_\_

Is it okay to leave a message if you do not answer?

Address: \_\_\_\_\_

Family member to be contacted in case of extreme emergency:

Phone: \_\_\_\_\_ Address: \_\_\_\_\_

Your age: \_\_\_\_\_ Your date of birth: \_\_\_\_\_ Social Security # (often required by the insurance co.) \_\_\_\_\_

How did you find out about my office?

What type of work do you do? \_\_\_\_\_ Employer \_\_\_\_\_

How many years of education have you completed?

**Medical History**

Have you had previous therapy? \_\_\_\_\_

Name of Therapist                      Dates                      Place                      Reasons

Was this therapy a positive experience?

Was medication prescribed?                      If so, what?

Was it effective?

If you are currently on any type of medication/ herbs/vitamins, please list with dosage and length of time you have taken it: (many affect mental health):

List any health problems:

Current doctor:

Phone:

Please circle any of the following problems you are experiencing:

- |                                      |                                 |                                    |
|--------------------------------------|---------------------------------|------------------------------------|
| 1) Academic                          | 2) Anxiety/stress disorder      | (3) Business/work related problems |
| 4) Drug/alcohol                      | 5) Eating disorder              | 6) Family Problems                 |
| 7) Financial problems                | 8) Gender role issues           | 9) Marital/partner problems        |
| 10) Medical problems                 | 11) Social skills               | 12) Physical abuse                 |
| 13) Sexual assault/incest            | 14) Problems with your children | 15) Sexual functioning             |
| 16) Mood disorder (depression, etc.) |                                 | (17) Legal                         |
| 18) Other                            |                                 |                                    |

How long have you been experiencing the current problem(s)?

Please briefly describe your current problem(s) in your own words: (use the last page for more space.)

**Family**

List the people **you** consider to be your family members. Please put a check mark in front of the names of those who live in your current home

Name                      Age              Relationship

Additional family members not in your current home:

If you have experienced a family divorce, how old were you?

If the divorce happened to you as a child, how old were you when your parents remarried?

Who are the other important persons in your life and where do they live? (First name and relationship)

Do you feel you have a good support system?

	Yes	No	Comments
Have you been in the military?			Dates:
Are you a sexual assault/incest survivor?			
Is there physical/emotional violence in your family?			
Have you been physically abused?			
Have you ever been arrested?			
Do you have problems with anger?			
Is there a family history of alcohol or drug abuse?			
Is there family history of mental illness?			
Do you cut, burn, mark yourself?			
Have you ever had an eating disorder?			
Have you been hospitalized for medical/emotional problems?			
Do you tend to have intense relationships where you alternate between feelings of trust and betrayal/anger?			
Do you have any serious medical problems? (many affect mental health)			

What are two or three major things that have happened to you that are important to the way that you think about yourself?

**Present Situation**

What is your living situation currently (family home, roommate, etc.)?

How many hrs per week are you employed?      In school?      What other major time commitments do you have?

What are some of your personal strengths?  
 If therapy accomplishes what you want, what will be different in your life at the end of therapy?

If religion or a particular philosophy is important to you in ways that might influence your counseling, please comment.

Can you make the commitment to bring up the issue of suicide if ( or when) it is an active part of your thinking? Have you had thoughts of suicide in the last month?

Have you ever attempted suicide? If so, when?

Please answer the following questions: STRONG OR GOOD PROBLEM-ATIC

How satisfactory is your current living situation?	1	2	3	4	5	6
How satisfactory is your relationship with your family?	1	2	3	4	5	6
How do you feel about your social skills?	1	2	3	4	5	6
How good do you feel about your body image?	1	2	3	4	5	6
How connected do you feel with friends and others?	1	2	3	4	5	6
How optimistic do you feel about the future?	1	2	3	4	5	6
How do you feel about your sexuality?	1	2	3	4	5	6
How satisfactory is your work situation	1	2	3	4	5	6

In the most recent month approximately how many days did you take medicine?

Drink alcohol?

Smoke or chew tobacco?

Use drugs to alter your mood or sociability?

Use prescription drugs other than in the way they were prescribed?

Binge on sugar?

Binge eat?

Vomit or purge?

Gamble?

Are you having financial problems?

How much Caffeine do you drink in a typical day (soda, coffee, or tea)?

Have you ever had a drug or alcohol problem? \_\_\_\_\_

Do you have problems with sleep?

Do you have pain problems?

Please use the back of this page to tell me things you feel are important for me to know.