Portland Processwork Clinic

Client's Name _____ Date of Birth _____

Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

May we call you and / or leave messages at home? ___ yes ____ no

Employer / School

_____

Relationship Status _____

Family Member's Name Relationship Age Occupation/School

_____

_____

_____

_____

Person who can be contacted in case of emergency?

Name_____

Address_____

Phone_____

Relationship _____

What brings you here?

_____

_____

Prior counseling? ___ yes ____ no

When and with whom?_____

_____

For what issues?

_____

_____

Current medical or physical issues?

_____

_____

Current medications (list all including dosage)

_____

_____

Do you drink alcohol? ___ yes ____ no

How often? _____ How much? _____

Do you use other substances? ___ yes ____ no

How often? _____ How much? _____

Physician's name _____

Address _____ Phone _____

How did you hear about the Portland Processwork Clinic?

_____

Signature _____

Date _____