



Willow Ann Rose LPC CHT NCC
282 East 18th Avenue
Eugene, Oregon 97401
Phone: (541) 461-5424
Fax: 541 343-1419

CLIENT QUESTIONNAIRE

The information you provide will be kept confidential as outlined in privacy and confidentiality guidelines set out in state and federal regulations. Please see my "Professional Disclosures" document for summary of these guidelines. Feel free to add any other information you feel may be useful. We will review this information and together, create a plan of services that will best support your personal goals. Please contact me with any concerns prior to completing this questionnaire or ask questions at any point in our work.

Name _____ Birthdate _____ Age _____

Is there a name you prefer I call you? _____

Address _____ City _____ Zip _____

May I send correspondence here? _____

Telephone Numbers _____

Best number for contact? What type of message may I leave?

Local Emergency Contact _____

Relationship to You? _____

How Were You Referred to Me? _____

If Internet, what site? _____

If using insurance, what is plan name? _____

Describe briefly what brings you to therapy. Please note when you first considered requesting services.

What are your goals for therapy and how will you know our work is helping?

What are your favorite stress management strategies?

What nourishes you? What do you do for fun?

Describe your strengths.

Briefly describe your spiritual or religious beliefs or the basic ethical guidelines that inform your life. If you were raised with a different belief system, what was it?

Are you currently in a primary relationship? If so, note duration, and briefly describe the quality of this relationship.

Who lives in your household? (number of people/ages/relationships) Are you happy with this arrangement?

Do you have children? Gender/Ages and Where Do They Reside?

How would you describe your circle of friends?

Please list current health concerns, locations of chronic pain and history/ dates for significant accidents, surgeries, illness or medical hospitalizations:

How would you describe your current nutritional choices?

Describe your sleep

What is your daily caffeine intake?

What kind of exercise do you get? How often?

Do you smoke cigarettes? How many per day?

Please list current Medications/Supplements/Herbs

Prescriber(s)

Please list any other health care practitioners, counselors or agencies you are currently working with.

Would it be helpful for me to exchange or provide information to any of these providers?
If so, which one (s)?

Do you have any history for addictions or alcohol/substance abuse? Describe current use: substance, amount, frequency of use.

Do you have any history for physical or sexual abuse? Are you a survivor of an armed conflict or natural catastrophe? Please briefly describe as much as you are comfortable at this time.

Previous Counseling? Please give date and briefly describe. Include Psychiatric Hospitalizations and Alcohol/Drug Programs. What was helpful or not helpful about the counselor, method or facility?

Have you ever experienced suicidal thoughts/feelings or actions? Please briefly describe.

Current: Occupation?

Employment/School/Daily Tasks/Responsibilities?

Briefly Describe Your Family Of Origin. Please indicate if you have siblings younger or older than yourself; who raised you and where; any relevant cultural/religious factors that particularly informed your upbringing. Also note any family history for addictions or mental illness.

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Other Information You Would Like to Offer at this Time?

I may offer or suggest a variety of approaches and modalities to best support your goals. It is essential to me that I offer strategies that honor, respect and support your spiritual, religious, cultural and traditional beliefs. I will also offer specific modalities at your request and if we decide a particular strategy may be of benefit to you. It will always be your choice to decide which modalities you are interested in working with.

Listed below are the basic modality descriptors for the therapeutic pathways I currently offer. There are many varieties of strategies under each of these labels. At this time, please put a check next to the modalities that you would like to engage in or further discuss.

-Psychotherapy

-Hypnotherapy

-Mindfulness/Contemplative Based Practices

Signature_____

Today's Date_____

Form Revised 11/2011