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Oregon Family Therapy, LLC

Individual, Couples and Family Therapist

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Please provide the following information. This information will help me provide you with the best services possible. Please answer all questions to the best of your ability. Information you provide here is held to the same standards of confidentiality as our therapy.

Please print out this form and bring it (completed) to your first session. If you are unable to print and complete this form, please allow yourself 10-15 minutes prior to your first appointment to complete the form in my office.

Client's Full Legal Name: _____
(Last) (First) (Middle Initial)

D.O.B. (MM/DD/YYYY): _____ Gender: Male Female

Parent's Address: _____

Home Phone: _____ May I leave a message? yes no

Cell/other Phone: _____ May I leave a message? yes no

Contact E-mail: _____ May I email you? yes no

*Please be aware that e-mail may not be confidential

Parent's Address: _____

Home Phone: _____ May I leave a message? yes no

Cell/other Phone: _____ May I leave a message? yes no

Contact E-mail: _____ May I email you? yes no

*Please be aware that e-mail may not be confidential

How did you find out about my services? _____

Is your child currently receiving psychiatric services, professional counseling or therapy elsewhere?

yes no If yes, where? _____

Have he/she had previous psychiatric services, professional counseling or therapy? yes no

If yes, please provide previous therapist's name: _____

Is your child currently taking any prescribed psychiatric medications (i.e. antidepressant?)

yes no If yes, please list current medications and dosage: _____

If no, have your child been previously prescribed psychiatric medications? yes no

If yes, please list: _____

HEALTH AND SOCIAL INFORMATION

How would you describe your child's current physical health?

Poor Unsatisfactory Satisfactory Good Very Good

Please list any persistent physical symptoms or health concerns (i.e. chronic pain, headaches, hypertension, asthma, diabetes, vision or hearing problems). _____

Is your child having difficulties with your sleeping habits? yes no

If yes, check where applicable:

sleeping too little sleeping too much poor sleep quality
 Difficulty falling or staying asleep Waking up too early
 Nightmares or distressing dreams Other _____

How many times per week does your child exercise? _____

What type of exercise does he/she do? _____

Any changes/problems with appetite or eating habits? yes no

If yes, check where applicable:

Eating less Eating more Binging Restricting

Has your child experienced significant weight change in the last 2 months? yes no

Have your child ever used drugs or alcohol? yes no

If yes, please describe:

Substance Amount Frequency (i.e. daily, weekly) Last Use:

Has your child ever experienced any of the following? (Please check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Extreme depressed mood | <input type="checkbox"/> Wild Mood Swings |
| <input type="checkbox"/> Rapid Speech | <input type="checkbox"/> Racing Thoughts |
| <input type="checkbox"/> Hallucinations (auditory, visual, tactile) | <input type="checkbox"/> Delusions |
| <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Frequent Body Complaints |
| <input type="checkbox"/> Repetitive Thoughts (i.e. Obsessions) | <input type="checkbox"/> Repetitive Behaviors (i.e. hand washing) |
| <input type="checkbox"/> Suicidal Thoughts/Thoughts of Self-Harm | <input type="checkbox"/> Homicidal Thoughts |

Please indicate which of the following issues/problems you would like to address in therapy:

- | | |
|--|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lack of friends |
| <input type="checkbox"/> Anxiety/Panic Attacks | <input type="checkbox"/> Grief/Loss |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Problems at School |
| <input type="checkbox"/> Phobias | <input type="checkbox"/> Problems at Work |
| <input type="checkbox"/> Sleep Disturbance | <input type="checkbox"/> Family Conflict |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Alcohol/Substance Abuse |

- Traumatic Event

 Victim of Abuse (physical or sexual)
- Other: _____

FAMILY MEDICAL/PSYCHIATRIC INFORMATION

Has anyone in your family had a serious medical condition? yes no

If yes, please explain: _____

Has anyone in your family (immediate or close relatives) experienced difficulties with the following?

Please check all that apply and list family member (i.e. sibling, parent, maternal aunt):

Difficulty:	Family Member	
Depression	<input type="checkbox"/> yes	<input type="checkbox"/> no
Bipolar Disorder	<input type="checkbox"/> yes	<input type="checkbox"/> no
Anxiety Disorders	<input type="checkbox"/> yes	<input type="checkbox"/> no
Panic Attacks	<input type="checkbox"/> yes	<input type="checkbox"/> no
Schizophrenia	<input type="checkbox"/> yes	<input type="checkbox"/> no
Alcohol/Substance Abuse	<input type="checkbox"/> yes	<input type="checkbox"/> no
Eating Disorders	<input type="checkbox"/> yes	<input type="checkbox"/> no
Learning Disabilities	<input type="checkbox"/> yes	<input type="checkbox"/> no
ADHD	<input type="checkbox"/> yes	<input type="checkbox"/> no
Trauma History	<input type="checkbox"/> yes	<input type="checkbox"/> no
Suicide Attempts	<input type="checkbox"/> yes	<input type="checkbox"/> no

OCCUPATIONAL /SCHOOL INFORMATION

School's name and current grade: _____

ADDITIONAL INFORMATION

If there is anything you think would be important for me to know that I did not ask about, please

write it here: _____
