Elaine J. Davis, LMFT *503-402-8654*

Adult Information Form

Name: _____Today's Date: _____Date of Birth: _____

Address: _____City:_____ Zip: _____

Age: _____ Gender: _____ Ethnic Background_____

Telephone: (home) _____OK to leave message? Yes ___ No ___

Telephone (cell) _____OK to leave message? Yes ___ No ___

E-mail address (if you want to use e-mail for communication) _____

Who can I call if there is an Emergency ? (Name someone you feel comfortable knowing you are in counseling)

Name: _____ Relationship_____

Phone #_____ Alternate # _____

Occupation (if employed): _____

Please describe the difficulties/issues that have brought you to see me:

_____

_____

_____

_____

What do you hope to have happen by coming to counseling: _____

_____

_____

_____

Please rate the severity of your concerns: (mild) 1 2 3 4 5 6 7 8 9 10 (severe)

Have you ever received psychological, psychiatric or counseling services before? Yes_____ No ____

If yes, please indicate approximately when, for how long and the reason for seeking services.

_____

_____

How helpful was it? 1 2 3 4 5 6 7 8 9 10

Not helpful Somewhat helpful Very Helpful

Are you currently working with another therapist in any capacity? Yes_____ No ____

Name of Therapist _____

Will you need a SuperBill/Invoice to submit to your insurance Yes____ No____ To whom should I send the monthly invoice to? _____

How did you locate my name?___Psychology Today ___Good Therapy.org ___Website ___Referral ___Other

If referred, who referred you? _____

May I contact this person or agency to acknowledge the referral? Yes _____ No ____