Deborah Orandon, MS,NCC, LMT
Self-Awareness Counseling
7409 SW Capitol Hwy #207
Portland, OR 97219
(503)729-9662

Date____________

Client Information Form

Name____DOB______________Gender__________

Address____

City____________________________County______________ State________ Zip____________

Primary phone________________________________ OK to leave confidential msg? yes no

Secondary phone______________________________ OK to leave confidential msg? yes no

(optional) Email _______________________________ OK to leave confidential msg? yes no

Would you like to be on e-mailing list for notice of Self-Awareness offerings and Body-Mind Newsletter? yes no

Occupation_________________________________ Employer___________________________

Work phone number___________________OK to contact at work?_______ confidential?______

Highest grade/degree completed____

Other specialty education?____

Currently in school? (if yes, what are you studying?)_____________________________________

Partnership status: (circle) Single Married Divorced Separated Partnered Widow/er

Spouse/ partner(s) Name:____Age:_________

Occupation:______________________Employer____________________________________

Names & ages children:____

Members of household—include name, age & relationship to you:________________________

____

____

Emergency Contact: ____

Name Number Relationship to you

Referred by:____

Current Medications:____

Last Hospitalization:____

Major Health Issues/Accidents:____

List general reasons for seeking counseling *at this time*: (use back of sheet if needed)