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Client Profile Form

Name _____ Date _____

The information you provide below will help me get to know you more quickly. If you have questions or reservations about answering any of the items, please star the item and we can discuss how best to approach the material during the session. Many questions I ask here will certainly have complex answers, and because we will delve much deeper into your experiences in therapy, for this initial overview, brevity is recommended.

The information you provide here is held to the same standards of confidentiality as is therapy with me. Confidentiality will be discussed in detail in your first therapy session and is outlined in my Professional Disclosure Statement.

(Please use the back of sheet if you need more space for your answers.)

Family of Origin Information:

▪ Where did you live as a child? (countries, states, towns) _____

▪ Please list the members of your household while growing up _____

▪ List your parent's or primary caretakers names & ages (or age at death) _____

▪ List your sibling's names & ages (or age at death) _____

▪ Are your parents together/married? _____ If not, when did they separate/divorce? _____

▪ Did you feel safe growing up in your household? In your neighborhood? If no, please explain _____

▪ Is there any history of physical or sexual abuse, substance abuse or mental illness in your family? If yes, please list: _____

▪ Did any members of your household have any chronic or severe medical illnesses, trauma or disabilities? If yes, please explain _____

- Is there anything left over from childhood that still disturbs or concerns you? _____

Social, Cultural, Spiritual & Identity Information

- Are you currently in a romantic relationship?_____If yes, how long have you been in this relationship?
_____On a scale of 1-10, how would you rate the quality of your current relationship?
_____ If you are not satisfied with it, what would you like to improve?_____

Are you currently or have you ever been in a relationship where you felt emotionally put down or physically threatened or harmed?_____If yes, Please briefly describe the situation_____

- Describe your social circle, are you satisfied with the quality and quantity of close relationships you have?
If not, please explain_____

- Are you involved with any groups or organizations that meet regularly? Please list_____

- Does your cultural and ethnic heritage play an important role in your life?____ If yes, what would you like me to know about it?_____

- Does spirituality, religion or religious upbringing play an important role in your life?____ If yes, what would you like me to know about it?_____

- Are there any other important ways that you identify yourself that you would like me to know about? (e.g. gender or sexual identity, lifestyle, counter-culture, etc.)_____

Physical/Medical History

- Describe your general Health, are you satisfied with it? _____

▪ Do you have any health concerns, illnesses, frequent pain or chronic conditions? _____ If yes, please describe: _____

▪ Do you have any sleep problems? _____ If yes, describe: _____

▪ Are you now under a doctor's care? _____ If yes, name of doctor _____
Reason for doctor's care _____

▪ Are you taking any medications, herbs, supplements? _____ If yes, please list type and reason for taking _____

▪ Date of Last medical, psychiatric, or naturopathic examination _____
▪ Have you ever had, or been hospitalized for a major physical illness, surgery or accident? _____ if yes, please list date(s) of occurrence(s) and describe: _____

▪ Do you smoke cigarettes? _____ If yes, how much/often? _____

▪ Do you drink? _____ If yes, how much/often? _____

▪ Do you take recreational drugs? _____ If yes, what kind and how often? _____

▪ What are your exercise habits? Please list type and frequency _____

▪ How are your eating habits? Are you satisfied with them? If not, please explain _____

▪ In general, what is your attitude toward your body? _____

▪ Is there anything else you would like me to know about your health or physical history? _____

Mental Health History

- Have you had any Previous Therapy/Counseling?_____ If yes, please describe by providing the following:
with whom?_____ When? _____ Length of treatment?_____
Satisfaction with treatment & what ended it?_____

(If you had more than one previous counseling experience, please describe each, in same detail as above—use back if necessary)

- Have you ever been hospitalized for a mental health crisis?____Describe: dates, circumstances, length of stay_____

Did you receive follow up care?_____ If yes please describe _____

- Are you currently taking any psychiatric medications?_____ If yes, please list _____

- Are the medications helpful? Explain_____

- Please list the most stressful aspects of your life _____

- How would you rate your ability to handle stress on a scale of 1-10 (10= excellent coping skills) _____
- Have you experienced any significant life changes or increased stressors in the last few years?_____ If yes, please explain_____

Current Situation & Hopes for Counseling

- What do you consider to be your strengths?_____

▪ What are some of your favorite activities? _____

▪ What do you like most about yourself? _____

▪ What do you hope will change as a result of therapy? _____

▪ What have you tried in the past to change the situation? _____

▪ How will your life be different if these changes occur? _____

▪ How do you hope I might help? _____

▪ Are there any legal issues going on currently in your life? _____ If yes, please list _____

▪ Is there anything else you would like me to know? _____
