Head & Heart Therapy
917 SW Oak St. Suite 303
Portland, OR 97205

Contact Information & Demographics

Client first name:_____

Last name:_____

Middle: _____ (optional)

Preferred name:_____

- ☐ Check box if client is a minor

Email address:_____

- ☐ Yes, it's okay to send appointment reminders to this email

Phone number: _____

- ☐ Yes, it's okay to send voice messages to this number
- ☐ Yes, it's okay to send texts to this number

Address:_____ Apartment:_____

City:_____ State:_____ Zip Code:_____

Birth Date:_____

Sex: This information is required if you are going to use insurance.*

- ☐ Male
- ☐ Female
- ☐ Prefer not to say*

Gender identity: List your gender identity, pronouns, or other info you'd like your provider to know.

_____

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Relationship status:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Domestic partnership
- ☐ In long-term relationship
- ☐ Separated
- ☐ Widowed

Employment status:

- ☐ Full-time
- ☐ Part-time
- ☐ Self-employed
- ☐ Unemployed
- ☐ Full-time student
- ☐ Part-time student
- ☐ Retired
- ☐ Homemaker

Emergency Contact

First name:_____

Last name:_____

Relationship:

- ☐ Child
- ☐ Family member
- ☐ Legal guardian
- ☐ Physician
- ☐ Parent
- ☐ Partner
- ☐ Spouse
- ☐ Other

Email address:_____

- ☐ Yes, its okay to send messages to this email
- ☐ Yes, send appointment reminders to this email

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Phone number:_____

- ☐ Yes, it's okay to send voice messages to this number
- ☐ Yes, it's okay to send text messages to this number

- ☐ No, don't send appointment reminders to this number
- ☐ Yes, send text appointment reminders to this number
- ☐ Yes, send voice appointment reminders to this number

Insurance Information

Insurance Company:_____

Member ID:_____

Group ID:_____

Client's relationship to insured

- ☐ Client
- ☐ Client's spouse
- ☐ Client's parent
- ☐ Other

Insurance card: Please let an admin scan your insurance card(s) for our records. You may also send us photos of the front and back of your insurance card(s) via text message to 971-200-0482 or by email to headandheartinfo@gmail.com.

We have implemented a policy which enables you to maintain your credit card information on file with Head & Heart Therapy. In providing us with your credit card information, you are giving Head & Heart Therapy permission to automatically charge your credit card on file for your session fee, co-pay, or deductible at time of service. This agreement will remain in effect until the expiration of the credit card account and you may revoke this form at any time by submitting a written request.

The card may automatically be charged in the event of a late cancellation (less than 48 hours' notice), a no-show or missed appointment.

I, _____, authorize Head & Heart Therapy to charge my credit card above for session fees, co-pays, deductibles and outstanding balances

on my account. I understand that my information will be saved to file for future transactions on my account.

Credit Card Information

Name on card:_____

Card number:_____ Expiration:_____

Security Code (CCV):_____ Zip code:_____

New Client Questionnaire

Please take some time to answer the following questions. You're welcome to skip over any questions you would prefer not to answer. Your responses will help your therapist get an idea of what is going on for you. Also please know that therapy looks different for different people, therefore we encourage you to be vocal as to what might be helpful for you during this process.

What are your pronouns?

What brings you to counseling at this time?

When did you first start to notice these issues coming up?

What do you hope to get out of therapy / What are your goals for treatment?

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Any current or past physical health (medical) issues?

Have you previously received therapeutic services before, and if so, when and why?

If you have received therapy in the past, what did you find helpful and unhelpful?

Please check any of the following you have experienced in the past six months.

- ☐ Depressed mood
- ☐ Racing thoughts
- ☐ Unable to enjoy activities
- ☐ Impulsivity
- ☐ Anxiety attacks
- ☐ Difficulty falling asleep
- ☐ Hallucinations
- ☐ Issues with concentration
- ☐ Decreased need for sleep
- ☐ Suspiciousness
- ☐ Overeating
- ☐ Undereating
- ☐ Excessive energy
- ☐ Chronic fatigue
- ☐ Self-harm behaviors
- ☐ Decreased libido
- ☐ Excessive guilt
- ☐ Increased irritability
- ☐ Crying spells
- ☐ Constant fear of abandonment
- ☐ Aggressive physical behavior
- ☐ Aggressive verbal behavior
- ☐ Hopelessness
- ☐ Worthlessness
- ☐ Flashbacks
- ☐ Nightmares
- ☐ Feeling numb
- ☐ Panic attacks
- ☐ Health issues/past surgeries
- ☐ Isolation from others

Please note any family members that have struggled with mental health and/or addiction issues.

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Please select the following statements that often feel true for you:

- ☐ I'm not good enough
- ☐ I don't deserve love
- ☐ I am a failure
- ☐ I have to be in control
- ☐ I have to be perfect
- ☐ I can't handles it
- ☐ I am powerless/helpless/trapped
- ☐ I am responsible
- ☐ I should have done something
- ☐ I cannot trust anyone
- ☐ I cannot protect myself
- ☐ It's not safe/okay to show/feel emotions

Any thoughts of hurting yourself, past or present?

What do you do for self-care/fun?

What is your level of education? Highest grade/degree and type of degree.

What do you consider to be your personal strengths?

How do you learn best?

- ☐ Visual
- ☐ Auditory
- ☐ Experiential
- ☐ Other:

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Do you consider yourself religious or spiritual? If so please describe.

What is your current occupation / how do you spend your time?

Describe your current living situation. Do you live alone, with others, with family, etc.

Who are important people in your life? People that you can be yourself around. Feel free to include animals as well.

If you are in a relationship, please describe the nature of the relationship and how long you've been together. It may also be helpful to know if you are monogamous or polyamorous and your sexual orientation.

Please note any current or past substance use, including how often you use(d) that substance. Include substances such as caffeine, nicotine, alcohol, opiates, hallucinogens, etc.

Please note any psychiatric medication that you are currently taking along with the dosage and name of your prescriber.

Do you have any allergies? If so, what are your allergies?

How do you feel about the idea of having "homework" to complete outside of weekly therapy?

Any issues you have around sleep?

What time do you generally go to sleep?

What time do you generally wake up?

How long (in minutes) does it generally take you to fall asleep at night?

How many hours of actual sleep would you say you get each night (rather than the amount of time you spend in bed)?

How often do you exercise, and if you do, what do you do to stay active?

I cannot go through the day without worrying about what I will or will not eat

- ☐ Almost always
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

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Please select any of the following that you might be interested in:

- ☐ EMDR
- ☐ CBT
- ☐ DBT
- ☐ Art Therapy
- ☐ Animal-assisted Therapy
- ☐ Group Therapy
- ☐ Rapport building activities (Jenga, Connect Four, etc.)

How long do you anticipate being in therapy for?

Are you okay with dogs joining us in session?

Are you okay with scents/aromatherapy in the office?

How did you hear about Head & Heart Therapy (please be specific as possible)?

Anything else that you would like me to know about you?