ACACIA RISING COUNSELING
Roxanne George, Ph.D., CADC-1, LMFT (License No. T0762)
Honoring Strength and Diversity in Individuals, Couples, and Families
1345 NW Wall Street, Suite 303, Bend, OR 97701; 389-5050 (Phone); 678-5482 (Fax)
Email:acaciarising@proaxis.com; Website: www.acaciarising.com

Client Code: _____ Therapist Initials: _____ Today's Date:_____

Welcome to *ACACIA RISING COUNSELING*. Please take a few minutes to complete this form. If you have any questions or concerns about this form, or don't know what to write, please feel free to leave the space blank until you meet with me.

Information About You

Your Name and Address: Full Name: Address: City, State: Zip Code:	**Your Phone Number(s):** ❑ Check here if it is ok for me to call you here ❑ Check here if it ok for me to leave messages here. ***Is there anything I need to know about contacting you here?***
Date of Birth (mm/dd/yy): **Social Security Number:**	**Emergency Contact Person:** Name: Relationship: Phone:
Primary Care Physician: Name: Phone:	**Current Medications** **Dosage** **Frequency**

Veteran: YES ___ NO ___	**If a Vet, Dates Served:**	**Disability: YES ___ NO ___**
Gender (Circle One) 1. Female 2. Male 3. Other [*specify* _____]	**Sexual Orientation (Circle)** 1. Heterosexual 2. Homosexual 3. Bisexual 4. Transsexual 5. Other [*specify* _____]	**Relationship Status (Circle)** 1. Single 2. Partner/Significant Other 3. Married (Legal or Common Law) 4. Separated/Divorced 5. Widowed 6. Other [*specify* _____]
Level of Education Completed 1. 11th Grade or Under 2. High School Diploma/GED/Voc. 3. Some College or AA Degree 4. BA/BS Degree 5. Graduate Degree 6. Other [*specify* _____]	**Ethnic/Cultural Background (Circle)** 1. White 2. African-American 3. Latino/Latina/Hispanic 4. American/Alaskan Native 5. Asian/Pacific Islander 6. Mixed Race 7. Other [*specify* _____]	**Religious/Spiritual Orientation** 1. Christian 2. Jewish 3. Muslim 4. Hindu 5. Buddhist 6. Spiritual 7. Other [*specify* _____]
Employment Status (Circle One) 1. Full-time (36 hrs/wk or more) 2. Part-time (less than 36 hrs/wk) 3. Unemployed w/govt. assistance 4. Unemployed, no govt. assistance 5. Retired or 6. Student 7. Other [*specify* _____]	**Household Income Sources (Circle)** 1. Earned income from employment 2. Unemployment benefits 3. Retirement/Pension 4. Child Support 5. Welfare/AFDC 6. SSI/SSDI 7. Other [*specify* _____]	**Household Pre-Tax Annual Income** 1. None 2. Less than $6,000 (< $500/mo) 3. $6,001 - $12,000 ($500-$1000/mo) 4. $12,001-$24,000 ($1000-$2000/mo) 5. $24,001-$36,000 ($2000-$3000/mo) 6. More than $36,000 (> $3,000/mo)

Referral Source	Phonebook ___	Brochure ___	Professional _____	Other _____

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Information About Your Family

Who currently lives in your home and what is their relationship to you?		
Name	**Age**	**Relation to you?**
1.		
2.		
3.		
4.		
5.		

Previous Counseling or Therapy History

Have you seen a counselor or therapist in the past? (if yes, please give the name or agency) **May I contact them? YES _____ NO _____**	**Are you currently seeing another counselor or therapist? (if yes, please give the name or agency and phone number)** **May I contact them? YES _____ NO _____**
If you have been in counseling or therapy in the past, **What was most helpful for you?** **What was least helpful for you?**	

About Your Reason For Contacting Me

Please describe your reason for seeking counseling at this time.
How long has this issue been influencing you and your life?
Who else is aware of, involved in, or influenced by this issue? In what ways?
What have you tried to do to resolve the problem?
Did any of these help with the problem? Explain.

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Other Information That May Be Useful In Assisting You (Circle All Italicized & Underlined Items That Apply)

A1) *Are you / have you* ever been in a relationship where **YOU** were threatened, stalked, spied on, controlled Circle: *financial; social; emotional; damaged/ vandalized property; verbally insulted and/or put you down?* A1a) If yes, what is the approximate number of single incidents that occurred in the relationship(s)? A2) *Are you / have you* ever behaved this way towards **SOMEONE ELSE**? A2a) If yes, what is the approximate number of single incidents that occurred in any of your relationships?	Yes No _____ Yes No _____
B1) *Are you / have you* ever been in a relationship where **YOU** were *physically / sexually* mistreated or hurt? (B1a) If yes, what is the approximate number of single incidents that occurred in any of your relationships? B2) *Are you / have you* ever behaved this way towards **SOMEONE ELSE**? (B2a) If yes, what is the approximate number of single incidents that occurred in any of your relationships?	Yes No _____ Yes No _____
C1) *Are you / have you* ever been in a relationship where **YOU** felt hesitant to express your views? C2) *Are you / have you* ever been in a relationship where **SOMEONE ELSE** was hesitant to express views?	Yes No Yes No
D1) *Are you / have you* ever been in a relationship where **YOU** felt afraid of your partner? D2) *Are you / have you* ever been in a relationship where **SOMEONE ELSE** felt afraid of you?	Yes No Yes No
Note: Questions E1 through E4 include the use of prescription medications and supplements E1) *Are you / have you* ever been concerned about or negatively impacted by **YOUR** *alcohol / drug* use? E2) *Are you / have you* ever been concerned or negatively impacted by **SOMEONE ELSE'S** *alcohol / drug* use? E3) Has anyone ever expressed concern or been negatively impacted by **YOUR** *alcohol / drug* use? E4) Have you ever participated in a *support group / counseling* due to **YOUR** *alcohol / drug* use? E5) Have you ever participated in a *support group / counseling* due to **SOMEONE ELSE'S** *alcohol / drug* use? E5) Has someone close to you participated in a *support group / counseling* due to **THEIR** alcohol / drug use?	 Yes No Yes No Yes No Yes No Yes No Yes No
F) Have you ever intentionally caused harm to yourself? When / How?	Yes No
G) Have you ever been diagnosed with a mental illness? When / What?	Yes No
H) Are you or have you ever been involved with Child Protective Services? When / Why?	Yes No
I) Are there any current legal involvement's going on in your life? Explain	Yes No
J) Are you or is somebody close to you dealing with any medical concerns? Who?	Yes No
K) Have there been any recent deaths or losses in your family or among your friends? Who?	Yes No
L) Have you or someone close to you had any other recent changes? Explain	Yes No

M) Are you currently experiencing any difficulties in the following areas (check all that apply)

❑ Alertness	❑ Concentration	❑ Anxiety/Fidgety	❑ Menstrual Changes
❑ Appetite	❑ Memory Loss or Pblms	❑ Depression/Sadness	❑ Reproductive Changes
❑ Breathing	❑ Pain Management	❑ Bipolar/OCD/IDC	❑ Sexual Intimacy
❑ Numbness	❑ Stomach/Digestion	❑ Suicidal Thoughts	❑ Sexual Confusion
❑ Dizziness/Faintness	❑ Weight Loss/Gain	❑ Thoughts of Harming Self or Others	❑ Other _____
❑ Headaches/Migraines	❑ Change in Appetite		_____

N) Is there anything else I didn't ask about that you are struggling with or would like assistance with?

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Family / Relational Assessment

Read each item below to see if it describes how your partner or family member usually treats you. Circle the number that best describes how strongly you agree or disagree with whether it applies to you. Your answers are confidential and will not be shared with your partner.	**Do Not Agree At All**				**Strongly Agree**
(1) My partner/family member never admits when he/she is wrong.	1	2	3	4	5
(2) My partner/family member is unwilling to adapt to my needs and expectations.	1	2	3	4	5
(3) My partner/family member is more insensitive than caring.	1	2	3	4	5
(4) I am often forced to sacrifice my needs to meet my partner's/family member's needs.	1	2	3	4	5
(5) My partner/family member refuses to talk about problems that make him/her look bad.	1	2	3	4	5
(6) My partner/family member withholds affection unless it would benefit him/her.	1	2	3	4	5
(7) It is hard to disagree with my partner/family member because he/she gets angry.	1	2	3	4	5
(8) My partner/family member resents being questioned about the way he/she treats me.	1	2	3	4	5
(9) My partner/family member builds himself/herself up by putting me down.	1	2	3	4	5
(10) My partner/family member retaliates when I disagree with him/her.	1	2	3	4	5
(11) My partner/family member is always trying to change me.	1	2	3	4	5
(12) My partner/family member believes he/she has the right to force me to do things.	1	2	3	4	5
(13) My partner/family member is too possessive or jealous.	1	2	3	4	5
(14) My partner/family member tries to isolate me from family and friends.	1	2	3	4	5
(15) My partner/family member sometimes physically hurts me.	1	2	3	4	5
Total Score:					

For each of the items listed below, circle the number that most accurately represents the quality of your current relationship.	**Quality of Relationship**			
	Poor	**Average**	**Good**	**Excellent**
a. The communication quality/integrity of my relationship (e.g. talking, listening, respect of differing views, non-verbal cues, making time) is…	1	2	3	4
b. The friendship quality / integrity of my relationship (e.g. shared interests or hobbies, shared fun & laughter, comfortable & easy to be with, enjoy being with) is…	1	2	3	4
c. The emotional quality / integrity of my relationship (e.g. caring, support, emotional closeness, warmth, ability to hear/acknowledge/empathize with others' feelings) is…	1	2	3	4
d. The physical quality /integrity of my relationship (e.g. touching, hugging, affection, sexual intimacy, respect of physical boundaries) is…	1	2	3	4
e. The romantic quality / integrity of my relationship (e.g. romance, attraction, fire) is	1	2	3	4

During conflict, I often feel (circle the most appropriate representation) with my partner/family member:

Thank you for taking the time to fill this out. I look forward to being able to assist you!