Ryan Hofrichter, MS, LPC Intern
Individual, Couples, and Group Counseling
4531 Southeast Belmont Street, Suite 310 · Portland, Oregon 97215
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Client Questionnaire

Client Name:		Today's Date:
Mailing Address:		
E-Mail Address:		Phone Number(s):
Would you like to receive appointment reminders by e-mail? ❑ Yes ❑ No		Okay to leave a message? ❑ Yes ❑ No
What's the easiest way to reach you?		Any limitations I should know about when contacting you?
Date of birth:	Gender Identity:	Ethnic Identity:
Emergency contact name:	Phone: E-Mail:	Relationship to you?
By whom where you referred?	May I thank this person for their referral? ❑ Yes ❑ No	
Occupation and place of work:		
What's the highest level of education you've completed (circle one)?	Middle School High School Undergraduate Graduate	
What is your relationship status?	❑ Single ❑ Partnered ❑ Separated ❑ Married ❑ Divorced ❑ Other:	
Do you have any children? ❑ Yes ❑ No	If yes, names and ages:	
Your children live with you: ❑ Full time ❑ Part time ❑ They do not live with me	Please describe custody arrangements (if applicable):	

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Have you ever physically harmed yourself or someone else, or had thoughts of such harm?

Past: ❑ Yes ❑ No **Current**: ❑ Yes ❑ No

If yes, please describe:

Have you ever given serious thought to ending your own or someone else's life?

Past: ❑ Yes ❑ No **Current**: ❑ Yes ❑ No

If yes, please describe:

Have you ever made an attempt to end your life or someone else's life?

Past: ❑ Yes ❑ No **Current**: ❑ Yes ❑ No

If yes, please describe:

Are you experiencing violence or abuse at home, work, or in any other setting?

❑ Yes ❑ No

If yes, please describe:

Are there any legal issues affecting you at this time?

❑ Yes ❑ No

If yes, please describe:

Are you currently taking any medication? ❑ Yes ❑ No Dietary supplements? ❑ Yes ❑ No

If yes, please list names of medication/supplement, purpose, dosage, and frequency taken:

Are there any significant health issues affecting you?

Physician's name and phone number:

Are you currently under the care of any other health care providers? ❑ Yes ❑ No

What kind of provider(s)? ❑ MD ❑ LMT ❑ ND ❑ PMHNP ❑ LAc ❑ DC ❑ Other

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Why are you seeking counseling at this time? What aspects of your life would you like to explore and/or change?

Please rate the level of distress the following issues have caused you within the past year (mark #1-4 next to each issue):

0	1	2	3	4
None	Minor	Moderate	Considerable	Extreme

__ Alcohol
__ Caffeine
__ Drugs
__ Finances
__ Job
__ Past Trauma
__ School
__ Spirituality
__ Health or Medical Condition
__ Anger
__ Cultural Concerns
__ Eating
__ Grief or Loss
__ Legal
__ Phobias
__ Sexual Identity
__ Tobacco
__ Communication
__ Anxiety
__ Depression
__ Family
__ Gender Identity
__ Obsessions/Compulsions
__ Relational Conflict
__ Sleep
__ Violence/Abuse

Have you received counseling before? ❑ Yes ❑ No

Type, length of time and approximate dates:

How did you feel about the process? What helped, or not?

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Describe your lifestyle habits:

Eating and nutrition:

Exercise and physical activity (times per week, type, duration):

Sleep (average number of hours per night, deep or light; ease or difficulty getting to sleep or staying asleep):

Substance use (frequency and amount of use):

Describe your social and community support:

Describe some of the things you enjoy doing, as well as some of things you do to take care of yourself or feel good:

What do you consider to be your skills and strengths?

Do you have any spiritual or religious beliefs that are important to you? ❑ Yes ❑ No. If yes, please describe:

Is there anything else you'd like me to know?

The information that I have provided on this form is true and accurate to the best of my knowledge:

_____ _____
Client Signature Date

Would you like to receive occasional updates by e-mail about other offerings? (e.g. groups, workshops)? ❑ Yes ❑ No