

**Laurie Crandall, LMFT, LPC**

*Family and Individual Therapist*

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## Your Information

Please fill out what you are comfortable sharing and bring to the first session with you

Name \_\_\_\_\_ Date \_\_\_\_\_

Gender Identity \_\_\_\_\_

Date of birth \_\_\_\_\_ Age \_\_\_\_\_

Home Address \_\_\_\_\_

City/State \_\_\_\_\_ Zip \_\_\_\_\_

Parent's email \_\_\_\_\_

Parent's Primary Phone (home/cell/work) \_\_\_\_\_

Check if o.k. to leave message \_\_\_\_\_

Alternate Phone (home/cell/work) \_\_\_\_\_

Check if o.k. to leave message \_\_\_\_\_

Who lives at home with you? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Name

Relationship

Phone

Emergency Contact(s) \_\_\_\_\_

\_\_\_\_\_

School and Grade \_\_\_\_\_

Do you have an IEP? \_\_\_\_\_

Ethnic/Cultural Background (optional) \_\_\_\_\_

Spiritual Practice/Religious Affiliation (optional) \_\_\_\_\_

How did you find me? \_\_\_\_\_

### **Family History**

In a few words, describe general relationship with the following people.

Mother: \_\_\_\_\_

\_\_\_\_\_

Father: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Brothers and sisters (include names and ages): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other significant family members: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you experienced any of the following?:

\_\_\_\_ Raised by someone other than parent (who? \_\_\_\_\_)

\_\_\_\_ Parents divorced (your age \_\_\_\_)

\_\_\_\_ Lived with step-parent or other siblings

\_\_\_\_ Adopted (at what age? \_\_\_\_)

\_\_\_\_ Other \_\_\_\_\_

Have you experienced the death of someone close to you? (yes/no)

Please give the name and relationship of the person(s), cause of death, and when they died (or your age at the time): \_\_\_\_\_

Do you have a history of abuse or neglect? \_\_\_\_\_

Is there a family history of mental illness (depression, anxiety, attention deficit disorder, addictions, suicide, etc.)? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Health**

Current physical health concerns: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any current or previous developmental concerns? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you follow a specific diet? \_\_\_\_\_ Why? \_\_\_\_\_

Prescribed medications you are taking and what are they for: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Previous mental health hospitalizations, diagnoses, medications: \_\_\_\_\_  
\_\_\_\_\_

Previous medical hospitalizations, serious illnesses or injuries, seizures, or head injuries: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How active are you? Do you exercise? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you been to counseling before (include approximate dates, length of time, and reasons)?

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Was it helpful? \_\_\_\_\_

Any concerns about substance abuse or any other impulsive behaviors? \_\_\_\_\_

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Describe how much time you spend on media (TV, movies, Internet, news, Facebook, etc...)\_\_\_\_\_

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### **Self Care**

What stuff stresses you out? \_\_\_\_\_

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Are there things you do to help you relax or coping skills that you use? \_\_\_\_\_

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What are some of your personal strengths and/or things you are good at? \_\_\_\_\_

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What are your hobbies or things you like to do? \_\_\_\_\_

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Who can you turn to for support (family/friends)? \_\_\_\_\_

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How much do you usually sleep? Do you have a hard time getting to sleep or staying asleep?

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**Therapy Goals**

What brings you to therapy at this time? (Please describe the issues and concerns for which you are seeking counseling.) \_\_\_\_\_

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How do you hope your life will be different after counseling? \_\_\_\_\_

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