



Ashley C. Collins, M.Ed, PCP
OmTara Counseling
omtaracounseling@gmail.com
503.381.4562

Client Intake Form

Your Name:

Today's Date:

Address:

Email:

Phone: (cell)

OK to leave
message? Yes

No

Phone: (home/work)

OK to leave
message? Yes

No

Date of Birth:

Age:

Gender:

Occupation:

Education:

Relationship Status: Single Partnered Married Divorced Widowed Separated

Person I can contact in case of emergency:

Name:

Phone Number:

Please list the current members of your household:

Name:

Age:

Relationship to You:

Name:

Age:

Relationship to You:

Name:

Age:

Relationship to You:

Name:

Age:

Relationship to You:

Name:

Age:

Relationship to You:

Briefly describe your reason(s) for seeking counseling:

What do you hope to gain from counseling?



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Any history of trauma? Sexual, physical, emotional abuse, neglect, accidents, surgeries, etc.:

Please list significant losses you have experienced. Deaths, divorce, perinatal and health related loss, etc.:

Please list any medical problems or physical symptoms. Major medical issues, surgeries, accidents, falls, illness:

May I contact your Primary Care Physician? Yes No

Primary Care Physician's Name:

Address:

Phone:

Please list any current prescription medication you are taking:

NAME OF MEDICATION	DOSE	TAKEN FOR	PRESCRIBED BY



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Personal history of alcoholism, mental illness or violence. Including suicide, depression, hospitalizations in mental institutions, abuse, etc.:

Family medical history. Describe any illness that runs in the family: cancer, epilepsy, etc.:

Family history of alcoholism, mental illness or violence. Including suicide, depression, hospitalizations in mental institutions, abuse, etc.:

Are you involved in any current or pending civil or criminal litigation, lawsuit, divorce or custody dispute?
(if you answer Yes, please explain):

Friendships, community and spirituality. Describe quality, frequency, activities, etc.:

What are your hopes for the future? Activities, goals, dreams, ways of being:

Who suggested that you contact me for services?
