MARCIA JOHNSTON WOOD, Ph.D.
Clinical Psychologist
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5441 SW Macadam, #104, Portland, OR 97239
Phone (503) 248-4511/ Fax (503) 248-6385

CLIENT INFORMATION

1. IDENTIFYING INFORMATION

Name: _____ Date: _____

Address: _____ City, State, Zip _____

Telephone(s) _____ _____ _____ _____
(Cell) (Work) (Home) (Other)

May I leave messages on cell? Yes □ No □ At work? Yes □ No □ At Home + "Other"? Yes □ No □

Your email address: _____ May we communicate through email? Yes □ * No □

**(By checking Yes, you understand that sending Personal Health Information through email is not generally considered a secure method of communication and I do not encrypt my email)*

Gender Identification: M____ F____ Age: _____ Birthdate: _____

Your Ethnicity/Cultural Identification(s): _____

Marital Status: _____ Spouse/Partner (if any): _____

Your Sexual/Affectional Orientation/Identity: _____

Education: Self: _____ Spouse/Partner's: _____

Occupation: _____ Spouse/Partner's: _____

Employer: _____ Spouse/Partner work phone: _____

Who referred you to me? _____

Emergency Contact: _____ Phone(s): _____ _____
(Cell) (Work or Home)

Relationship to Emergency Contact: _____

Family Members Names	Relationship	Age	Occupation/School	Lives with You?
_____	_____	____	_____	_____
_____	_____	____	_____	_____
_____	_____	____	_____	_____
_____	_____	____	_____	_____

2. Please Describe the Primary Problem(s) for Which You are Seeking Therapy at This Time:

_____

_____

_____

_____

_____

_____

Please check any of the symptoms that you are having or have had very recently:

___ Depression	___ Feeling hopeless	___ Extreme sadness
___ Trouble concentrating	___ Change in sleeping habits	___ Feeling helpless
___ Change in eating habits	___ Weight changes	___ Memory problems
___ Trouble performing your job	___ Lack of energy	___ Acting violently
___ Obsessions or compulsions	___ Self-esteem problem	___ Change in sexual interest or function
___ Physical complaints of pain	___ Easily irritated	___ Concern about sexual orientation
___ Thoughts about hurting yourself	___ Feeling nervous	___ Feeling guilty
___ Thoughts about hurting others	___ Muscle tension	___ Feeling of extreme happiness
___ Thoughts about killing yourself	___ Feelings of panic	___ Lack of enjoyment of usual activities
___ Thoughts about killing others	___ Problems with anger	___ Perfectionism
___ Problems getting along with family/others		___ Feeling stressed

___Other:_____

_____

3. PREVIOUS MENTAL HEALTH TREATMENT

A. Please tell me about your previous therapists, if any: ____ Check here if none.

Name	Dates of Treatment	Reason for Treatment	Outcome

_____

_____

B. Please tell me about any psychiatric hospitalizations: ____ Check here if none.

_____

_____

4. MEDICAL INFORMATION

Your Primary Physician: _____ Phone: _____

Other Treating Physicians/Nurse Practitioner: _____ Phone: _____

Please list current medical conditions:

1. _____
2. _____
3. _____

Please list any allergies:

1. _____
2. _____

Current Medications:

Name	Dosage/Day	Condition Treating	Who Prescribing	How long have you taken?
1.				
2.				
3.				
4.				

Indicate problems or conditions you have currently (use "**C**") or have had in the past (use "**P**"):

___ Headache	___ Eye, ear, nose, throat	___ Diabetes	___ Mumps
___ Faintness	___ Skin	___ Epilepsy	___ Prostate problem
___ Dizziness	___ Genital	___ Heart disease	___ Rheumatic fever
___ Sleep problems	___ AIDS	___ Hepatitis	___ Scarlet fever
___ Muscle/joint/bone	___ Alcoholism	___ High cholesterol	___ Stroke
___ Weakness	___ Appendicitis	___ HIV positive	___ Thyroid problems
___ Numbness	___ Arthritis	___ Kidney disease	___ Tonsillitis
___ Urinary	___ Asthma	___ Liver disease	___ Tuberculosis
___ Appetite problems	___ Cancer	___ Measles	___ Ulcers
___ Stomach/bowel	___ Chemical dependence	___ Multiple sclerosis	___ Sexually transmitted disease
___ Chest pain	___ Chicken pox	___ PMS/Hormonal issues	

When was your last complete physical exam? _____

Please list any major hospitalizations, with dates and condition treated:

1. _____
2. _____

5. EXERCISE:

Do you exercise and /or play a sport regularly? If so, describe what and how often: _____

_____

_____

6. SUBSTANCE USE HISTORY

Please indicate if you currently use or have used in the past the following substances:

	Past	Current	Amount		Past	Current	Amount
Tobacco/cigarettes	____	____	_____	Cocaine	____	____	_____
Alcohol	____	____	_____	Mushrooms	____	____	_____
Caffeine (includes coffee, colas etc.)	____	____	_____	LSD	____	____	_____
				Psychedelics	____	____	_____
Marijuana	____	____	_____	Sleeping pills	____	____	_____
Tranquilizers	____	____	_____	Crank/crack	____	____	_____
Pain killers	____	____	_____	Amphetamines	____	____	_____
Over-the-Counter meds	____	____	_____	Inhalants	____	____	_____
Prescription meds	____	____	_____	Other (specify) _____			
Sleeping pills	____	____	_____	_____			

Do you now use, or have you in the past used, any of the above substances excessively? If so, please list time period and amounts of excessive use:

_____

_____

Please list any past or current facilities for substance abuse treatment (specify dates):

1. _____
2. _____

7. OTHER HISTORY

A) Education

___ Less than 12 years (specify highest grade completed) _____
___ High School
___ College (# of years completed if no degree) _____ where? _____
___ Master's Degree (specify degree and where) _____
___ Doctoral Degree (specify degree and where) _____

Did you receive special education? ____ Yes ____ No Learning Disability? ____ Yes ____No

B) Occupation: Please list past job titles and dates

1. _____
2. _____
3. _____
4. _____

C) Family Psychiatric History

Please tell me about any family psychiatric history, including diagnoses and hospitalizations if you know them:

_____

_____

_____

_____

_____

_____

- THANK YOU FOR THE TIME AND EFFORT TO FILL THIS OUT -

(Revised 12/13)