Sol Marie Doran
MA, LMHC, SEP

RIVER VALLEY PSYCHOLOGICAL SERVICES
5837 221st Pl. SW
Issaquah, WA 98027
425-391-0887

GENERAL INFORMATION

Client Legal Name: Preferred Name: Date:

Age: Date of Birth:

CONTACT INFORMATION

Street Address: Suite/Apt. #:

City: State: Zip Code:

May I send mail there? (Circle) Y N

Mailing Address (if different than above):

City: State: Zip Code:

May I send mail there? (Circle) Y N

(Please provide at least one address where you can receive mail.)

Cell Phone: Okay to receive message there? (Circle) Y N

Home Phone: Okay to receive message there? (Circle) Y N

(Please provide at least one phone number where you can receive a message. Note that, due to HIPAA, texting and email will not be used.)

OVERVIEW

Why are you seeking counseling? How long have these things felt challenging?

What are some things that are working better than others in your life?

What are some things you are grateful for, even if things feel hard?

PRESENTING CHALLENGES

Issue	Past	Present	Explain a Little
Aggressiveness			
Alcohol Abuse			
Anger			
Anxiety			
Apathy			
Change in Appetite			
Claustrophobia			
Compulsivity			
Confusion			
Delusions			

Issue	Past	Present	Explain a Little
Depression			
Difficulty Breathing			
Digestive Upset			
Dizziness			
Drug Abuse			
Eating Issues			
Emotional Abuse			
Fatigue			
Fears			
Finances			
Grief/Loss			
Headache			
Hearing Noises/Voices			
Hopelessness			
Housing Challenges			
Impulsive Behavior			
Infidelity			
Job Issues			
Lack of Direction			
Legal Challenges			
Loneliness			
Loss of Control			
Making Decisions (challenges)			
Memory Issues			
Nervousness			
Nightmares			
Obsession(s)			
Pain			
Panic			
Physical Abuse			
Racing Thoughts			
Rapid Heart Rate			
Reproductive Issues			
Seeing Things			
Self-Injury (Cutting, Picking, etc.)			
Serious Illness			
Sexual Abuse			

Issue	Past	Present	Explain a Little
Sexual Problems			
Sleep Trouble			
Social Anxiety			
Suicidal Thoughts			
Suicide Attempts			
Family/Friend Attempted Suicide			
Family/Friend Completed Suicide			
Stress			
Tactile Hallucinations			
Trauma			
Trouble Focusing			
Trouble Relaxing			
Unhappiness			
Unwanted Thoughts			
Verbal Abuse			
Visual Hallucinations			
Weakness			
Work Issues			
Other_____________________			

Have you been in counseling before? (Circle) Y N

If so, approx. dates, names. phone & fax numbers of prior counselors:

Are you willing to sign a release of information (ROI) so that your past counselor(s) and I can share information pertinent for your care? (Circle) Y N Unsure

Have you ever had a mental health/psychiatric diagnosis? (Circle) Y N

Diagnosis/Diagnoses:

Have you ever had any psychiatric hospitalizations? (Circle) Y N

When, where, and for what reason?

Please take a little break. This can sometimes be a lot of information to consider. Just look around the space you're in for a while. What do you see that your eyes would like to look at that looks neutral or pleasant? What do you physically notice about it?

MEDICAL INFORMATION

Primary Care Physician: Phone: Fax:

Mailing Address:

City: State: Zip:

Psychiatric Physician Phone: Fax:
(If applicable)

Mailing Address:

City: State: Zip:

Are you willing to sign a release of information (ROI) so that your doctor(s) and I can share information pertinent for your care? (Circle) Y N Unsure

On a scale of 1-10, how comfortable are you in communicating personal information to your doctor(s)? (1 being "not at all"/10 being "completely")

Are you currently receiving medical treatment for a particular concern? (Circle) Y N

Please specify:

Previous conditions, illnesses, injuries, surgeries, or medical hospitalizations: (Date and Type)

Do you take Vitamin D? If so, dosage & frequency:

Have you had the following tested?

Test	Approx. Date	Level (High? Low? Normal?)
Vitamin D		
Thyroid		
Diabetes		
Testosterone		
MTHFR gene mutation		

Approximately how much water do you drink per day?

Do you feel that this is adequate?

Do you feel that your diet supports you well?

Are there ways that changing your diet would support you more fully? If so, what would you change and how might that be helpful?

Do you exercise? (Circle) Yes No

If so, what kind and with what frequency & intensity?

Is there anything that might support you more fully in terms of exercise?

Do you take any medications or supplements?

Medication/Supplement	Dosage & Frequency	Purpose	Approx. Start Date	Prescribed by

Do you have any allergies? (Circle) Yes No

If yes, to what and indicate mild, moderate, severe but non-anaphylactic, or anaphylactic. Please also describe reaction:

Do you use alcohol? (Circle) Yes No

What kind? How often? What size are the drinks?

Are you experiencing challenges with alcohol? How about in the past? (Describe):

Do you use drugs? (Including cannibis) (Circle) Yes No

What types, how often, and how much?

Do you think there are problems in your life associated with drug use? How about in the past? (Describe):

Do other people in your life think that drugs or alcohol are challenges for you? Who? Do you agree with them?

Please be honest. Disclosing these things can often be uncomfortable, but it will be much easier to help you if you are forthright.

EDUCATION/EMPLOYMENT

Last schooling completed: (Circle) 9th 10th 11th 12th GED AA BA/BS Graduate Post-Graduate Trade Professional

Currently in school? (Circle) Y N Type: (If yes)

How do you feel about being in or not in school?

Employer: Length of Employment:

Occupation: Avg. Hours/Week:

How do you feel about this job?

Employer: Length of Employment:

Occupation: Avg. Hours/Week:

How do you feel about this job?

RELATIONSHIPS, SEXUALITY, & GENDER IDENTITY

Gender Identity: Gender Assigned at Birth:

Have you experienced any challenges related to your gender identity? (Describe):

Sexual Orientation:

Have you experienced any challenges related to your sexual orientation? (Describe):

Current relationship status: (Circle)

Single Separated Divorced Partnered Engaged Broken Engagement Married

Monogamous Monagamish Polyamorous Other (Describe):

Are you content with your current relationship status/format? (Circle) Y N If "no", briefly explain:

Are you in more than one relationship? (Circle) Y N If "yes", briefly explain:

How would you describe your partner(s)?

Partner Name: Age: Length of Relationship:

Their Gender Identity: (Circle) Male Female Other (Describe):

Sexual Orientation: Race(s)/Ethnicities(s):

Partner Name: Age: Length of Relationship:

Their Gender Identity: (Circle) Male Female Other (Describe):

Sexual Orientation: Race(s)/Ethnicities(s):

RACE, CULTURAL, & ETHNIC IDENTITY

Race(s)/Ethnicities(s): Cultural Identities(s):

How strongly do you identify with your racial, ethnic, & cultural identities?

Have you ever experienced any challenges related to these? (Describe):

Are there ways in which your heritage or cultural identity has provided blessings, opportunities, or strengths? (Describe):

CHILDREN

Child's Name	Date of Birth	Current Age	Living?	Relationship (Bio, Step, Adopted, Guardian)	Placed for Foster Care/Adoption?	Lives with you? Someone Else?

Have you ever experienced a miscarriage? (Circle) Y N Approx. Date:

Have you ever experienced an abortion? (Circle) Y N Approx. Date:

If you do not have a child, do you want one? (Circle) Y N

If yes, are there any challenges involved? (Circle) Y N

Describe:

FAMILY OF ORIGIN (Who you grew up with)

Name	Relationship to You	Date of Birth	Living or Deceased	Your Enjoyment of Relationship, 1-10 scale

Is there anything you'd like me to know about these relationships?

Have any of your family members experienced emotional/mental health challenges or hospitalizations? What kind?

Have any of your family members experienced drug or alcohol challenges or treatment? What kind?

LEGAL ISSUES

Current/Past Arrests (Date/Description):

Current/Past Convictions (Date/Description):

Jail/Prison Time (Date/Description):

Restraining order(s) by or against someone? (Date/Description):

Child custody proceedings? (Date/Description):

Other (Date/Description):

SUPPORT SYSTEMS

What people, places, activities, pets, practices, etc. do you feel supported by? Please describe.

Do you have particular spiritual/soulful beliefs or practices? How important are these to you? Please describe.

Do you belong to a spiritual/soulful community? Please describe.

Do you have a sense of connection with nature? Please describe.

GOALS

What are you wanting in your life in general? What are your goals, desires, or longings?

What are your goals in counseling?

TERMS OF SERVICE

"I certify that the above information is complete and truthful to the best of my current knowledge and ability. I understand that my personal information is kept confidential, unless an exception is made according to the Privacy Notice, which I have received."

"I agree that, while receiving services from Sol Marie Doran, MA, LMHC, SEP, I will not choose suicide or homicide. I have received and read a copy of the Disclosure & Consent to Treatment and understand exceptions to confidentiality, including regarding potential harm to self or other."

"I understand that, as a part of my treatment, a diagnosis and treatment plan will be composed. These are an important part of receiving supportive and accurate care."

"I understand that email and texting are not HIPAA-compliant nor confidential means of communication and I will only communicate in person or via voicemail or mail, unless HIPAA-compliant technology becomes available or there is a change in relevant law."

"I understand that my counselor is legally and ethically bound to provide services within their scope of practice and that, should my needs fall outside of that, a referral will be provided (if available) instead of or in addition to services with Sol Marie Doran, MA, LMHC, SEP."

"I understand that honest communication is essential to a good counseling relationship and I agree, to the best of my ability, to communicate honestly with my counselor and let them know any needs that I am having related to my care."

"I request & consent to counseling treatment by Sol Marie Doran, MA, LMHC, SEP. I understand that I have the right to refuse or terminate treatment at any time and that I may choose my own counselor."

Signed: ____ Date: __________