

Anne W. Meneakis, LCSW
503-349-6152

Client Information Sheet

Client's Name: _____ DOB: _____ Age: _____ Intake Date: _____
Address: _____
Hm Phone: _____; Wk Phone: _____; Cell Phone: _____
Please initial next to whichever phone number(s) I may I leave messages for you.

Spouse/Significant Other: _____ May I leave
messages for you with this person? _____.

Please name someone I may contact in case of an emergency, or situations of urgent
safety concerns: _____ Please note what their
relationship is to you _____ Please note the best phone number(s) at which I may
reach them _____.

Whom were you referred by: _____ ?

Primary Physician: _____ Clinic: _____ Phone: _____
Please note any current medical concerns _____
Please note if you have any specific medical symptoms or difficulties for which you are
presently receiving treatment _____
Please note the names of any other medical providers involved in your medical care at
this time. _____
Please list any medications you are taking, including dosages
_____.

Please describe concerns you would like to address in your mental health/counseling
treatment: _____

Please describe specific outcomes you would like to achieve through your therapy
sessions/services _____

Do you have any safety concerns at this time? _____ yes _____ No
Please note any safety concerns that you may have _____.
