Rae Sidlauskas, MS, LMFT Intern
Corvallis Therapy, LLC ◆ 218 NW 6th Street ◆ Corvallis, OR 97330
541-286-5363 ◆ www.corvallistherapy.com ◆ rae@corvallistherapy.com

Welcome! Please complete this form and bring it with you to your first session.
If there are any questions you are uncomfortable or uncertain about answering, feel free to leave them blank.

Name: _____ DOB: _____

Mailing Address: _____

E-mail Address: _____

Phone #: _____ Type: _____

OK to leave message at this number? ☐Yes, any message ☐Yes, call back # only ☐No message

Alternate phone # (optional): _____ Type: _____

OK to leave message at this number? ☐Yes, any message ☐Yes, call back # only ☐No message

Emergency Contact Name: _____

Relationship: _____ Phone #: _____

I give my permission for Rae Sidlauskas to contact the above named person in the event of an emergency (please initial) _____

When was your last physician appointment? _____

Please list any medications (prescription or OTC) you are currently taking: _____

_____

_____

What is your educational background? _____

What is your primary occupation and/or source of income? _____

What is your annual household income? _____ What is your ethnicity? _____

How do you identify in terms of gender? _____

What is your sexual orientation? _____

Current: relationship status: _____

Length of relationship(s) if applicable: _____

Please list names and ages of others living in your home: _____

_____

_____

Please identify any spiritual practices that are part of your life: _____

_____

_____

_____

How did you hear about me?

What is motivating you to seek therapy at this time, and how long has this been influencing you/your life?

Who is involved in and/or aware of these factors in your life?

What have you tried to do to resolve these matters on your own? In what way(s) was this helpful?

What changes do you hope for as a result of therapy, and what are your thoughts about how I might be of help?

What might interfere with you achieving your goals in therapy?

What personal strengths and supports in your life will help you achieve your goals in therapy?

If you have received any mental health treatment in the past, please identify approximate dates, concern(s) addressed, and the clinician you worked with:

What about past treatment was helpful / unhelpful?

Do you have or have you previously had any legal issues (e.g. DHS involvement, restraining order, imprisonment, parole/probation)? If so, please summarize.

Have you or anyone close to you had any recent changes, such as job loss, recent moves, etc.? ☐Yes ☐No

Have there been any recent deaths or losses in your family or among your friends? ☐Yes ☐No

Are you or anyone close to you dealing with any medical concerns? If so, please describe briefly: ☐Yes ☐No

Have you ever suffered a head injury? ☐Yes ☐No

Do you currently use alcohol, drugs, or tobacco? If so, what and how often? ☐Yes ☐No

Have you or anyone else ever been concerned about your current or past use of alcohol or other drugs, including prescription medication or supplements? ☐Yes ☐No

Do you have any concerns regarding your diet and exercise patterns? ☐Yes ☐No

Do you currently experience, or have you ever experienced, visual or auditory hallucinations or paranoia for any length of time? ☐Yes ☐No

Are you currently utilizing, or have you ever utilized, self-harming behaviors (e.g. cutting self, banging head, burning self) for any reason? ☐Yes ☐No

Have you ever felt suicidal or attempted suicide? ☐Yes ☐No

Have you ever had to lie to people important to you about your gambling? ☐Yes ☐No

Have any other behaviors ever been a concern to you or to important people in your life? ☐Yes ☐No

At any time during your childhood did you see or hear someone in your household being physically or emotionally harmed or neglected? ☐Yes ☐No

Have you ever been emotionally or physically mistreated in a significant and ongoing way by an intimate partner or parent/guardian (e.g. being told you were stupid, being restricted from activities, being hit, kicked, etc.)? ☐Yes ☐No

Have you ever been made to have some form of unwanted sexual contact? ☐Yes ☐No

Have you ever seriously harmed anyone physically, or had the intent to seriously harm someone? ☐Yes ☐No

Are you currently experiencing any difficulties or concerns in the following areas?

- ☐ Alertness/Concentration
- ☐ Appetite
- ☐ Body image concerns
- ☐ Breathing
- ☐ Conflict in relationships
- ☐ Depression/Sadness
- ☐ Dizziness/Faintness
- ☐ Eating habits
- ☐ Interest in life
- ☐ Irritability
- ☐ Isolating from others
- ☐ Memory
- ☐ Motivation
- ☐ Numbness
- ☐ Pain management
- ☐ Racing or negative thoughts
- ☐ Sexual problems
- ☐ Sleep
- ☐ Stomach pains
- ☐ Stress management/Anxiety
- ☐ Weight loss or gain

What have I not asked about that you would like me to know?