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ADULT INITIAL INTERVIEW FORM

Date: _____

Client Information:

Name: _____ Date of Birth: _____ Sex: (circle) M F

Address: _____

Phone: (H) _____ (W) _____ (C) _____

Spouse or Significant Other's name: _____

Please initial: Is it ok to leave a message with the person/number(s) listed above? ____ Yes ____ No.

Conditions of approved messages: _____

Primary reason you are seeking counseling: _____

Describe any symptoms or problems arising from your primary concern described above: _____

What do you hope to achieve in counseling? _____

Employer: _____

Position: _____ How long have you worked there? _____

Education (list high school, trade school, college, degrees, etc..) _____

Primary Physician: _____ Phone: _____

List any significant health problems: _____

List any medication you are presently taking and the reason you are taking: _____

Have you been in counseling before? Yes _____ No _____

If yes, when? _____ Name of therapist: _____

Give brief description of issues worked on: _____

Referred by (therapist, physician, friend, website, brochure, etc...) _____

Nearest relative, other than spouse: _____

Phone: _____ Relationship to you: _____

First names and ages of all children: _____

Symptoms I am Experiencing:

My mood is: Sadder than usual More elevated than usual Changeable Tearful Irritable Angry
 Explosive Avoidant I feel fearful I feel panic I feel anxious I no longer enjoy the things I used to

Sleep: It's hard to go to sleep I wake up often in the night I sleep too much I have frequent nightmares
 I sleep _____ hours per 24 hour period

My thoughts: I hear voices in my mind I see things that may not be real I believe people can read my thoughts
 I believe I can read other people's thoughts My mind never seems to shut off I have unwanted thoughts that seem out
of my control I sometimes wish I were dead I have thoughts of hurting or killing myself /others I have a plan for
suicide

Behaviors: I can't stop counting I can't stop washing my hands I can't resist checking things I pull my hair or pick
at my skin I cut, burn, or scratch myself

Substances: I have used alcohol or drugs to cope I sometimes think I might have a problem with drugs or alcohol
 Other people have told me that I have a problem with alcohol or drugs I have unsuccessfully tried to stop using drugs
and/or alcohol

FINANCIAL INFORMATION

Financially Responsible Person:

Name: _____ Relationship to client: _____

Address: _____

Phone: (H) _____ (W) _____ (C) _____

Social Security Number: _____ Date of Birth: _____

Employer: _____

Financial Agreement:

Your fee per 45-50 minute session is \$ _____

In fairness to your counselor and to other clients, please provide 48 hours notice if you have to cancel or reschedule. If you miss an appointment without notifying my office, a standard fee of \$25 per missed visit will be billed to you.

YOUR PAYMENT IS TO BE PAID IN FULL AT THE TIME OF EACH SESSION. FEES ARE RE-VALUATED AND
SUBJECT TO CHANGE EVERY 6 MONTHS.

Thank you so much for taking the time to answer these questions. Please sign below indicating that you accept the fee agreement and have received and read a copy of my “What to Expect in Counseling” form and are aware of your rights and grievance procedures.

Client's Signature

Date

PLEASE BRING THIS COMPLETED FORM WITH YOU TO YOUR FIRST APPOINTMENT