



LARA ANDERS Marriage & Family Therapist

1904 Skypark Dr., Medford OR 97504

(541) 292-9452 or (541) 773-2999

[lara@adaptmedford.com](mailto:lara@adaptmedford.com)

### New Client Assessment Form

Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_

Phone: \_\_\_\_\_

(Can you receive texts on this number?)      Yes            No     

Are you interested in therapy?      Individual      Marriage      Therapy  
(please circle)

How did you hear about us? \_\_\_\_\_

Religious affiliation: \_\_\_\_\_

How do you plan to pay for therapy?      Cash            Check        
Debit/Credit            Bishops Assistance        
HAS account     

If Bishop will be assisting financially, please include his name, address to send bill to and phone #

\_\_\_\_\_

\_\_\_\_\_

Marital Status:

- Married
- Divorced
- Widowed

- Single
- Recent break up

Names and ages of family members: \_\_\_\_\_  
\_\_\_\_\_

Current health problems: \_\_\_\_\_  
\_\_\_\_\_

List all medical conditions and medications currently taking for those: \_\_\_\_\_  
\_\_\_\_\_

Are you currently being treated by another therapist: \_\_\_\_\_

Name and Phone # of doctor prescribing medications: \_\_\_\_\_  
\_\_\_\_\_

Counseling history (prior Diagnoses & dates of treatment): \_\_\_\_\_  
\_\_\_\_\_

Was the outcome of past therapy successful? Please describe what worked and what didn't:  
\_\_\_\_\_  
\_\_\_\_\_

- |                         |                          |                                    |                          |
|-------------------------|--------------------------|------------------------------------|--------------------------|
| Check all that apply:   | <input type="checkbox"/> | Unusual eating patterns            | <input type="checkbox"/> |
| Anxiety                 | <input type="checkbox"/> | Desire to not be touched           | <input type="checkbox"/> |
| Depression              | <input type="checkbox"/> | Hopelessness                       | <input type="checkbox"/> |
| Difficulty sleeping     | <input type="checkbox"/> | Thoughts of body image             | <input type="checkbox"/> |
| Obsessive thoughts      | <input type="checkbox"/> | Felling out of control             | <input type="checkbox"/> |
| Fear/Worry              | <input type="checkbox"/> | Lack of motivation                 | <input type="checkbox"/> |
| stress in relationships | <input type="checkbox"/> | Compulsive eating                  | <input type="checkbox"/> |
| Headaches               | <input type="checkbox"/> | Thoughts of harming self or others | <input type="checkbox"/> |
| Angry outbursts         | <input type="checkbox"/> | Guilt                              | <input type="checkbox"/> |
| Mood swings             | <input type="checkbox"/> | Perfectionism                      | <input type="checkbox"/> |
| Desire to be alone      | <input type="checkbox"/> | Social Phobias                     | <input type="checkbox"/> |
| Addictions              | <input type="checkbox"/> | Fear of failure                    | <input type="checkbox"/> |
|                         |                          | Flat emotions                      | <input type="checkbox"/> |

What is the main reason you are here today: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe what things would look like if the main problem was solved: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe past successes in this area: \_\_\_\_\_  
\_\_\_\_\_

List additional issues you'd like to work on in therapy:  
\_\_\_\_\_  
\_\_\_\_\_

List your strengths: \_\_\_\_\_  
\_\_\_\_\_

Sign: \_\_\_\_\_  
Date: \_\_\_\_\_

This form is strictly CONFIDENTIAL: