Michelle Engblom-Deglmann, PhD

LICENSED MARRIAGE AND FAMILY THERAPIST, LICENSE #T1004

12570 SW 69th Avenue
Portland, OR 97223

(503) 974-6563
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Individual/Family Information

Name____ Date of Birth _______________

Gender: _________________ Education Completed_______ Religion (if any) ______________________

Occupation __________________________Employer____

Home Address____

Home Phone _________________ Work Phone __________________ Mobile Phone _________________

Place an asterisk (*) next to all numbers at which it is okay to leave messages.

Spouse/Partner's Name __________________________ Date of Birth _______________

Gender: _________________ Education Completed_______ Religion (if any) ______________________

Occupation __________________________Employer____

Home Address (if different than above) ____

Home Phone _________________ Work Phone __________________ Mobile Phone _________________

Place an asterisk (*) next to all numbers at which it is okay to leave messages.

Individual/Family combined annual income (circle one)

$0-49,999 $50-74,999 $75-99,999 $100-124,999 $125-149,999 $150,000+

Number of marriages (including current) for you _______ Your partner ______

Years of current marriage/relationship ____

Please list below all children from this or previous marriages/relationships whether or not they live in your household.

Name(s)   Age   Gender

____

____

____

____

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Please list below any medication(s) members of your family are currently taking.

Name *Medication* *Dosage*

____

____

____

Medical Concerns:

____

Physician:____ Phone:______________________

Date of last physical:__________________

Past Mental Health Service Providers (therapists, psychiatrists, etc.):

____

Are you willing to sign a release for me to coordinate care with them?: Yes No

Has anyone being seen ever abused drugs? Yes No If yes, who and which drugs:

____

____

Please list below any physical or emotional health problems that members of your family have suffered now or in the past (Include relevant extended family such as parents).

Name *Physical or Emotional Health Problem*

____

____

____

____

Has any member of your family ever participated in counseling or therapy? Yes No

Who?

____

Reason(s)?

____

What led you to end counseling or therapy?

____

____

What was your reaction to your previous counseling?

____

____

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Circle any of the following that are presently causing you difficulty:

Assertiveness	Health problems	Career choices	Separation
Parenting	Alcohol use	Legal matters	Self-concept
Sexual problems	Marriage	Religion	Divorce
Nightmares	Loneliness	In-laws	Temper
Self-control	Communication	My past	Suicidal thoughts
Nervousness	Lack of energy	Sleep	Decision making
Physical abuse	Children	Parents	Insomnia
Depression	Sexual abuse	Shyness	Guilt
Stress	Inferiority	Friends	Dating
Memory	Drug use	Headaches	Tiredness
Finances	Appetite	School	Unhappiness
Fears	Work	Confusion	Premarital

Other ________________________________

Please underline the items that are causing the MOST difficulty.

Have you ever considered suicide? Yes No

Have you ever attempted suicide? Yes No

If yes, when?

____

____

Briefly describe your reasons for seeking counseling.

____

____

____

____

How did you hear about me?

____

Signature of person filling out form:

____Date:__________________________