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2 Roads Crossing Healthcare, PC
15455 NW Greenbrier Parkway, Suite 240
Beaverton, Oregon 97006-8116
503-617-0450

PATIENT INFORMATION

Name: _____ Date: _____

Address: _____

_____

Date of Birth: _____ Age: _____ Email: _____

Phone: (H) _____ (W) _____ (Cell) _____

Alternative Modes of Communication

- Yes. You may send direct postal mail to the address listed above
- No. Please send mail to me at: _____

I give permission to be called at (please circle all that apply): Home Work Cell
You may leave a message for me at (please circle all that apply): Home Work Cell

Please list any restrictions and/or special instructions regarding contacting you: _____

_____

Emergency Contact

Name of person to contact in case of emergency: _____

Address: _____ Phone: _____

Relationship to you: _____

Relationship Status: _____

Number of years of education completed (High School = 12 years): _____

Occupation: _____

Place of employment/School: _____

Please list all individuals that you consider members of your immediate family (e.g. significant other, spouse, children, siblings, parents, etc.)

Name	Relationship	Age	Location

Who referred you to this office: _____ Reason for referral: _____

_____

Health

Primary Care Provider (PCP): _____

Date of last physical exam/visit or PCP: _____

Please list all current medications: _____

Please list all allergies that you have: _____

Please list any current health concerns: _____

_____

_____

Please list any past health problems/accidents/hospitalizations: _____

_____

_____

Previous use of mental health services (Names of providers and date(s) seen): _____

_____

Please check all of the following that currently apply to you:

____ I have no problems or concerns
____ Abuse
____Anxiety or fears
____Appetite/Eating Disturbances
____Anger
____Alcohol/Drugs (myself)
____Alcohol/Drugs (my family)
____Problems with Attention/Concentration/Distractibility
____Bizarre or unusual thoughts/behaviors
____Compulsive behaviors
____Depression
____Family problems (current or historical)
____Fatigue
____Financial concerns/Impulsive spending
____Grief/mourning/death/loss/divorce
____Impulsive/reckless behaviors
____Legal involvements or concerns
____Obsessions/Compulsions/Repetitive Actions
____Parenting/Children Issues/concerns
____Perfectionism
____Relationship concerns
____ Low self esteem/Poor self care
____Shy/Highly sensitive
____Sexual concerns (identity, desire, abuse, etc.)
____Sleep difficulties
____Suicidal thoughts/attempts
____Violent thoughts or actions
____Withdrawal/social isolation
____Work/employment related problems
____Other concerns

Briefly describe what brings you to seek psychotherapy now: _____

_____

Initial Treatment Goals

What do you want to change as a result of psychotherapy (please be specific): _____

_____

_____ _____

Signature of patient or personal representative Date

_____ _____

Printed name of patient or personal representative Relationship to patient