Pamela Woodroffe, LICSW, SUDP, MAC, CCTP
Lake City Professional Center
2611 NE 125th Street, Suite 206, Seattle, WA 98125
Phone: (206) 399-2622
Email: Woodroffe.counseling@gmail.com, Website: www.pamelawoodroffecounseling.com

Welcome. Please tell me about yourself

Date: _____ Name: _____
Date of Birth: _____ Age: _____Gender: _____
Street Address: _____
City, State, Zip Code: _____
Telephone: _____ Alternate phone: _____
Best times to reach you: _____
Your EmaiL _____
Which way/s may I contact you? _____

How did you learn of my services? _____
How did you find me? Referred by? _____
May I thank that person? (circle one) Yes No
May I add your name to an email list for my newsletter? (I never give or sell it) Yes No

Have you had any major life changes and stressors in the last two years? _____
_____
What brings you to therapy at this time? _____
_____
_____

Please think about this carefully before our first session:
What would you like to be different in your life by the end of our sessions?
_____
_____

Current work and relationships:
What is your current occupation? _____
Your employer/self-employment? _____

Your relationship status (married, single, significant partner)? _____
Your living arrangements – roommates, children, partner, spouse_____
_____

Emergency Contact Name: _____

Phone Number: _____ Relationship to you _____

Medical & prescriptions:
Name and phone of your primary care doctor _____

Name and phone of your psychiatrist or prescriber _____

See next page

Mental Wellness – Please circle answers and elaborate below

Name _____ Date _____

Are you taking medications that help your mental wellness? Yes No
If so, which? _____
Have you taken medications for mood in the past? Yes No
If so, which ones? _____
Have you seen a therapist or psychiatrist in the past? Yes No
When? Was it helpful and in what way? _____
_____
Have you ever been hospitalized for mental health concerns? Yes No
If so when? _____ For what symptoms? _____
_____
Past and present mental health diagnoses?
_____
Have you ever had a head injury? Yes No
If so, did you have changes in your cognitive abilities or learning style?
_____
Do you ever see or hear things that aren't there? Yes No
_____
Have you ever intentionally hurt yourself? By cutting? Yes No
_____
Have you ever tried to kill yourself? Yes No
_____
Have you ever had periods of your life where you felt like you
didn't need to sleep, engaged in risky, compulsive behaviors? Yes No
_____
Have you ever struggled with food? Bingeing? Purging? Yes. No
_____
Are you feeling depressed, hopeless or apathetic? Yes No
_____
Are you feeling anxious? Yes No
_____
Have you ever had panic attacks? Yes No
_____
Do you drink alcohol? If so, what kind and how much? Yes No
_____
Do you use marijuana? If so, how frequently? _____ Yes No

Do you use unprescribed drugs? If so, what kind and how frequently? Yes No
_____
Have you ever sought treatment for a substance use problem? Yes No
_____
Is there anything else you would like me to know?
_____