WEISSER WELLNESS
1210 Dry Hollow Road, Suite 6 • The Dalles, OR 97058 • 541-340-4076 (P) • 888-526-0535 (F)

Client Information

LEGAL NAME (Last, first, middle initial): _____PREFERRED NAME:_____

BIRTHDATE: _____ AGE: _____ SOCIAL SECURITY #: _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Other (please specify)_____

EMPLOYMENT STATUS: ☐ Employed (P/T or F/T) ☐ Unemployed ☐ Student ☐ Disabled ☐ Retired ☐ Other (please specify)_____

LEGAL GENDER: ☐ Female ☐ Male ☐ Transgender ☐ Non-Binary IDENTIFIED GENDER (if different)_____ Preferred pronouns_____

ADDRESS (Street and mailing if different):_____

CITY_____ STATE_____ ZIP CODE_____

HOME PHONE: _____ Message OK: Y / N CELL PHONE: _____Message OK: Y / N

EMAIL: _____

As a courtesy, Weisser Wellness offers appointment reminders. Please choose one of the following options:

☐ Call ☐ Text ☐ Email ☐ I do not want appointment reminders

HOUSEHOLD MEMBERS (other than you):

Name	Age	Relationship

EMERGENCY CONTACT: Name/Relationship_____Phone #_____

PRIMARY PHYSICIAN NAME/CLINIC: _____

PHYSICIAN ADDRESS & PHONE: _____

May I notify your primary physician that you have contacted me? Y / N
May I exchange information with your physician for the purpose of coordinating treatment? Y / N

OTHER RELEVANT HEALTHCARE PROVIDER/SPECIALIST:_____

PROVIDER ADDRESS & PHONE: _____

DENTIST: _____

DENTIST ADDRESS & PHONE: _____

_____ _____ _____
Client or Authorized Representative Printed Name | Client or Authorized Representative Signature | Date

Referred By/How Did You Hear About Us?

☐ I am a former client returning ☐ Friend or Relative ☐ Court/Legal ☐ School ☐ Minister/Priest/Rabbi
☐ Insurance Company ☐ Internet Search ☐ Dr/NP/PA/DO (name) _____
☐ MH Professional (name)_____ ☐ Other(please specify)_____

The following information can be helpful in me getting to know you. Please provide information as thoroughly as possible and feel free to include additional history as needed, using blank pages if needed.

What is bringing you in to mental health services at this time and are there any specific goals you've identified for therapy? _____

_____

_____

_____

_____

_____

_____

Have you ever participated in outpatient therapy for mental health or substance abuse/addiction? ☐ Yes ☐ No

If Yes, please provide names & approximate treatment dates for each provider seen in the space provided below.

Provider:_____ Dates:_____

Provider:_____ Dates:_____

Provider:_____ Dates:_____

Have you ever had inpatient treatment for psychiatric or substance abuse/addiction purposes? ☐ Yes ☐ No

If Yes, please provide the name(s) of the treatment facilities & the approximate dates for each stay.

Facility:_____ Dates:_____

Facility:_____ Dates:_____

Facility:_____ Dates:_____

Are you currently being treated by a psychiatrist? ☐ Yes ☐ No

If Yes, who are you currently seeing?

Provider: _____ Dates: _____

Are you being treated by a doctor or other health care provider for any current major medical issues? ☐ Yes ☐ No

If Yes, what are the medical issues and who treats you for them?

Issue:_____ Provider: _____Dates: _____

Issue:_____ Provider: _____Dates: _____

Issue:_____ Provider: _____Dates: _____

Issue:_____ Provider: _____Dates: _____

Are you currently prescribed any medications? ☐ Yes ☐ No

If yes, please list information as outlined below:

Medication	Dosage	Frequency	Reason	Prescriber

Please also list any over the counter medicines vitamins and/or herbal medications/supplements that you take regularly:_____

_____

_____