



Counseling Services of Portland

Suzie Wolfer LCSW • 503-224-3318

CLIENT INFORMATION & GOALS

Today's date _____

Name _____ SS# _____

Address _____

City _____ State _____ Zip _____

Home phone _____ Work phone _____

Fax number _____ Email _____

Date of birth _____ Who referred you? _____

Insurance Provider _____

Phone _____ Fax _____

Policy # _____ Group # _____

Spouse or partner _____ Phone _____

Relative or friend _____ Phone _____

Employer _____

Current prescription drugs _____

Homeopathic or herbal treatment _____

What brought you here? _____

If therapy was completely successful for you, what would you want to have accomplished upon completing our work together? _____

