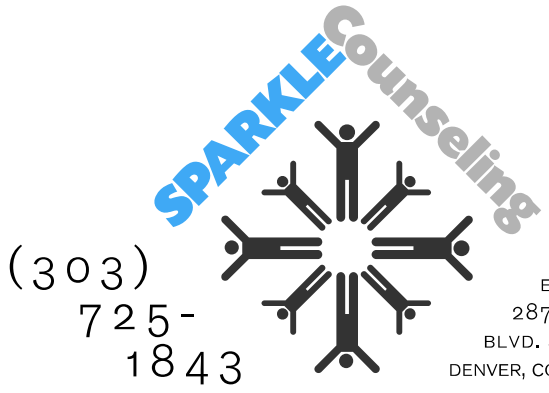

HIGHLAND EXECUTIVE CTR.
2870 N. SPEER BLVD. SUITE 206
DENVER, CO 80211

Name:_____ Today's date: _____

Address: _____

City: _____ State: _____ Zip:_____

County: _____ Home Phone:_____ msg ok?_____

Cell Phone: _____ msg ok? ____ Work Phone:_____ msg ok?_____

Email:_____ ok to email? _____

Social Security #: _____ D.O.B.: _____

Gender: _____ Race/Ethnicity: _____

Sexual Orientation:_____ Religious Preference: _____

Where do you attend worship? _____

Are your beliefs an important factor that you want included in counseling?_____

Employer:_____ School:_____

Spouse:_____ **Guardian:**_____

Address:_____ Address:_____

_____ _____

Phone:_____ Phone:_____

Mother:_____ **Father:**_____

Address: _____ Address:_____

_____ _____

Phone: _____ Phone: _____

Case Worker: _____ **Probation Officer:** _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

GAL: _____ **Attorney:**_____

Address: _____ Address: _____

_____ _____

Phone: _____Phone: _____

Emergency Contact:_____

Address & Phone:_____

INSURANCE (if applicable)

Name of insured: _____ Employer: _____

Insurance company: _____ Phone: _____

Insurance ID #: _____ Group #: _____

Insurance address: _____

INTAKE QUESTIONS

1. Describe any current concerns that have led you to seek counseling.

2. Have you experienced any of the following? (Please check those that apply):

___ Depression
___ Anxiety
___ Panic attacks
___ Trauma
___ Emotional, physical, or sexual abuse
___ Relationship difficulties
___ Unusual thoughts
___ Parenting issues
___ Perfectionism
___ Difficulty trusting others
___ Feelings of worthlessness
___ Insomnia
___ Life transition
___ Anger
___ Sexual difficulties
___ Drug Use
___ Suicidal ideation
___ Self-harm behaviors
___ Difficulty concentrating
___ Spiritual concerns
___ Seeing or hearing things
___ Behavior problems
___ Low self-esteem
___ Lack of hope
___ Rapid shift of moods
___ Eating disorders
___ Problems at school/work
___ Impulsivity

3. Please describe further any items checked in #2.

4. What have you done in the past to address these concerns?

5. Why have you decided to seek counseling now? What goals do you have?

6. Please list any past psychological treatment, the providers' names, their locations, and the dates you were seen.

SOCIAL HISTORY

Immediate Family
Marital status: __ Single __ Married __ Divorced __ Widowed
Name of spouse: _____
Names of children & ages:
_____
Who do you live with, and what is your relationship to those people?
_____
_____

Family of Origin
Mother: _____ Father: _____
Stepmother: _____ Stepfather: _____
Other: _____ Other: _____
Siblings (oldest to youngest, including yourself) Ages
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Describe yourself: _____
_____
_____
Describe your family: _____
_____
_____
Have you ever experienced physical, emotional, or sexual abuse? (If yes, please describe briefly):
_____
_____
Does anyone in your family have a history of depression, anxiety, or other mental health issues? (please describe):_____
_____

Does anyone in your family have a history of substance use/abuse? (please describe):

_____

_____

Who in your family were you closest to growing up? _____

Was/Is school a positive or negative experience? Why? _____

_____

What is the highest level of education you have completed? _____

Any legal troubles? ___ Yes ___ No Describe: _____

What are your stengths? _____

What are your hobbies? _____

What do you do to relax? _____ Have fun? _____

MEDICAL HISTORY & GENERAL HEALTH CONCERNS

Are you currently being treated by a physician for ongoing health issues? __Yes__No

Where do you go? _____

Do you have any physical complaints? Describe: _____

_____

How would you describe your current health? _____

_____

Describe any recent changes in the following:

Weight: _____

Appetite: _____

Sleep: _____

Are you currently pregnant? __ Yes __ No

Please list any drugs/medications, both prescribed and over the counter, that you are taking at this time:

Drug Name	*Dose*	*Frequency*	*Length of use*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you exercise regularly? __ Always __ Sometimes __ Never

List any allergies: _____

SUBSTANCE ABUSE HISTORY (TEENS/ADULTS ONLY)

Do you smoke? How much?_____ How long? _____

__ Yes__ No Have you tried to quit? _____

How old were you when you first used alcohol or drugs?_____

How old were you when you started using on a regular basis? _____

What is your drug of choice?_____

Which drugs are you currently using? _____

Date of last use: _____

What?_____
How much? _____

How often do you use substances? _____

How have you used in the past? __ Oral __ Intravenous __ Inhalation __Smoking

Do you presently share needles? ___ Yes ___ No

Have these substances ever caused problems for you? __ Yes __ Sometimes __ No
Describe: _____

Have you ever experienced the following when using (please check):

___ Blackouts
___ Convulsions
___ Hallucinations
___ Memory loss
___ Legal problems
___ Mood swings
___ Anger/fighting
___ Sweats
___ Paranoia
___ Vomiting
___ Insomnia
___ Family problems
___ Apathy/indifference
___ Loss of appetite

Describe the benefits you get from substance use:

_____

_____

Describe the mood you are generally in when you use:_____

Do you prefer to use in groups or alone?_____

Do you ever use heavily for periods of time? __ Yes __ No. How long? _____

What is the longest period of time you've gone without using? _____

What did you do to avoid use during this time?_____

_____

Have you ever been arrested due to substance use? __ Yes __ No

Have you ever lost a job or been suspended due to use? __ Yes __ No

Have you ever attended AA/NA/CA meetings? __ Yes __ No

Describe other programs or things you have tried to help with your use: _____

_____

Do you think you need to make changes to your use? __ Yes __ No

What changes? _____

What do you feel you need to be successful? _____

_____

Do you think you are an addict or have a substance abuse problem? __ Yes __ No

Describe any use in your family: _____

When was your last sexual contact, if ever? _____

How many partners have you had in the last 12 months? _____

Do you use a condom or other protection? _____

Have you been tested for HIV? __ Yes __ No Do you know your results? _____