

Highland Executive Center 22870 N Speer Blvd Suite 206 21 Denver, CO 80211 303-725-1843

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:	Address:		
Phone:	Phone:			
Case Worker:	Probation Officer:			
Address:		Address:		
Phone:	·			

I

Name: _____

Address & Phone: INSURANCE (if applicable) Name of insured: Employer: Insurance company: Phone: Insurance ID #: Group #: Insurance address: INTAKE QUESTIONS I. 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 Sexual difficulties Anxiety Drug Use Panic attacks Suicidal ideation Anxiety Drug Use Panic attacks Suicidal ideation Trauma Self-harm behaviors Emotional, physical, or sexual abuse Difficulty concentrating Relationship difficulties Spiritual concerns Unusual thoughts Seeing or hearing things Parenting issues Behavior problems		Attorney:	GAL:
Phone:Phone:Phone:		Address:	Address:
Emergency Contact: Address & Phone: INSURANCE (if applicable) Name of insured:			
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Relationship difficulties Spiritual concerns Unusual thoughts Seeing or hearing things Behavior problems			Trauma
Unusual thoughts Seeing or hearing things Behavior problems			• •
Parenting issues Behavior problems		•	•
		Seeing or hearing things	Unusual thoughts
Perfectionism Low self-esteem		·	Parenting issues
		Low self-esteem	Perfectionism
Difficulty trusting others Lack of hope		•	Difficulty trusting others
Feelings of worthlessness Rapid shift of moods		Rapid shift of moods	Feelings of worthlessness
Insomnia Eating disorders		Eating disorders	Insomnia
Life transition Problems at school/work		Problems at school/work	Life transition
Anger Impulsivity		Impulsivity	Anger
3. Please describe further any items checked in #2.		l in #2.	Please describe further any items checked

Name: _____

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.
so	CIAL HISTORY
Mai Nai Nai	nediate Family rital status: Single Married Divorced Widowed me of spouse: mes of children & ages:
Wh	o do you live with, and what is your relationship to those people?
Mo Ste Otł	nily of Origin ther: Father: pmother: Stepfather: ner: Other: ings (oldest to youngest, including yourself) Ages
Des	scribe yourself:
Des	scribe your family:
Hav	ve you ever experienced physical, emotional, or sexual abuse? (If yes, please describe briefly):
	es anyone in your family have a history of depression, anxiety, or other mental health issues?

3

Name:

Who in your family were you closest to growing up? Was/ls school a positive or negative experience? Why? What is the highest level of education you have completed? Any legal troubles?Yes No Describe:	Does anyone in you	ır family have a histor	ry of substance use/abo	use? (please des	scribe):
What is the highest level of education you have completed? Any legal troubles? Yes No Describe: What are your stengths? What are your stengths? Have fun? 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? Po you have any physical complaints? Describe: How would you describe your current health? Poscribe any recent changes in the following: Weight: Appetite: Steep: No Please list any drugs/medications, both prescribed and over the counter, that you are taking at time: Porug Name					
Any legal troubles? Yes No Describe:	Was/Is school a pos	sitive or negative exp	erience? Why?		
What are your stengths? What are your hobbies? What do you do to relax?					
What do you do to relax? Have fun?	Mhat are vour sten	Tes No Desi	cribe:		
Are you currently being treated by a physician for ongoing health issues?YesNo Where do you go?	What are your hob	bies?			
Are you currently being treated by a physician for ongoing health issues?YesNo Where do you go?	What do you do to	relax?	Have fun?		
Where do you go?	MEDICAL HISTO	ORY & GENERAL	HEALTH CONCER	RNS	
Do you have any physical complaints? Describe:					esNo
Describe any recent changes in the following: Weight:	Do you have any ph	nysical complaints? D	escribe:		
Weight:	How would you des	scribe your current h	ealth?		
Appetite:	-	_	•		
Are you currently pregnant?Yes No Please list any drugs/medications, both prescribed and over the counter, that you are taking at time: Drug Name	Appetite:				
Please list any drugs/medications, both prescribed and over the counter, that you are taking at time: Drug Name	Sleep:				
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?	Are you currently p	oregnant: i es i	NO		
Do you exercise regularly? Always Sometimes Never List any allergies: SUBSTANCE ABUSE HISTORY (TEENS/ADULTS ONLY) Do you smoke?	Please list any drugs time:	s/medications, both p	rescribed and over the	e counter, that	you are taking at t
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?	Drug Name	Dose	Frequency		Length of use
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How old were you when you started using on a regular basis?					
What is your drug of choice?	=		_		
Which drugs are you currently using?					

What? How much?							
How often do you use substances?							
How have you used in the past? Oral Ir							
Do you presently share needles? Yes	<u> </u>						
Have these substances ever caused problems for you? Yes Sometimes No Describe:							
Have you ever experienced the following who	en using (please check):						
Blackouts	Sweats						
Convulsions	Paranoia						
Hallucinations	Vomiting						
Memory loss	Insomnia						
Legal problems	Family problems						
Mood swings	Apathy/indifference						
Anger/fighting	Loss of appetite						
Describe the benefits you get from substance	use:						
Do you prefer to use in groups or alone? Do you ever use heavily for periods of time? _ What is the longest period of time you've gon	you use:						
Have you ever been arrested due to substance	e use? Yes No						
Have you ever lost a job or been suspended of	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 yo What changes?	our use? Yes No						
What do you feel you need to be successful?							
Do you think you are an addict or have a sub-							
•							
	12 months?						
Have you been tested for HIV? Yes No	Do you know your results?						