



Highland Executive Center ✨ 2870 N Speer Blvd Suite 206 ✨ 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: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

**Case Worker:** \_\_\_\_\_ **Probation Officer:** \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_

**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):

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

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

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.

## **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 strengths? \_\_\_\_\_

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:

<i>Drug Name</i>	<i>Dose</i>	<i>Frequency</i>	<i>Length of use</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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: \_\_\_\_\_

Name: \_\_\_\_\_

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

☐ 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:

\_\_\_\_\_

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? \_\_\_\_\_

Name: \_\_\_\_\_