Counseling Colorado, PLLC
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CONFIDENTIAL CLIENT INTAKE FORM

Today's Date______________________________

Name:____ Sex: M___F__

Date of Birth:_______________________ Age:_________ Ethnicity:_______________

Place of Birth____

Home phone:__________________________Work phone:_______________________

Cell phone:_____________________________

Home Address:____

City:______________________________ State:___________________ Zip_________

Emergency Contact: Name____

Relationship_________________ Phone Number(s)____________________________

Do you want Christian Counseling? ______Yes ______No

Relational Information

Current Marital Status: __Single __Engaged__Married__Divorce __Separated__Widowed

How long?____________________________

Spouse's Name____________________________ Age:_____________________

Please provide a brief description of your spouse (e.g., supportive, outgoing, angry, controlling)

____

With whom are you now living?____

Number of previous marriages for you?_____________For your spouse___________?

Who else lives with you? Why?

____

Please list your children (Including step, adopted, foster, or deceased) below:

Name Age Sex Living with whom/Relation to you

Family of Origin History

Father_________________________________Mother_____________________________

Living______Deceased______Year Living__________ Deceased_____Year_____

By whom were you raised?____

Where were you raised?____

Please list names and age of siblings and others you were raised with

Name Age Living/Deceased

Employment History

Current Occupation____

Name and Address of Employer____

____

How do you feel about your current position?___________________________________

____

Educational History

Highest Level of Education____________________________________

Did you Graduate?______________What Year?_________________

Social Activities
Religion:____

Church Attendance: Often Sometimes Seldom Never

Counseling History

Have you ever received counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care? Please list the names of the therapists or programs. (Use the back if necessary.)

Therapist/Psychiatrist	Major Issues	Outcome of Therapy (Date)

Have you ever taken or are you taking medication for psychiatric or emotional problems? Yes____No___

If yes, please indicate:

Which Medication/Why	When/How Long	With What Results

Do you or have you had thoughts of suicide? Yes______No_________

If yes, please explain____

Have you attempted suicide in the past? Yes_________ No_______

If yes, please explain (give date (s) method(s) and reason:

____

____

Has anyone in your family ever been treated or hospitalize for substance abuse, mental health issues, or psychiatric conditions? Yes_____   No________

If yes, please describe:____

____

Have any of your family members or friends ever attempted or committed suicide?___Yes___No

If yes, who, when and how?____

____

Chemical use (please Circle)
Do you have a chemical addiction? yes/no
How much beer, wine, or hard liquor do you consume each week on average?

____

Have you ever received a DUI? (Driving Under the Influence)_____Yes _____No

If yes, please describe when and where:_______________________________________

____

Have you ever used or are you using illegal drugs? What, When, Where, How Long?

____

____

Do you have any addictions? Please circle all that may apply.
Gambling, Sex, Food, Shopping, Caffeine, Nicotine,
Other describe:____

Legal History:

Are you presently in a legal dispute with anyone at this time? ____________________

With Whom?____

Reason for the Dispute:____

PRESENT ISSUES AND GOALS

Please describe why you are coming to counseling. (i.e. what are your issues, problems, symptoms, how long, etc. Use the back if necessary.):

____

____

____

Check any of the following symptoms or problems that you currently are or recently have experienced:

List 1 List 2 List 3
□ Stress □ Marital Problems □ Compulsive Behaviors
□ Anxiety □ Other Relational Problems □ Seeing Things Others Don't
□ Panic □ Physical Abuse □ Hearing Voices
□ Depression □ Emotional Abuse □ Racing Thoughts
□ Apathy □ Verbal Abuse □ Eating Problems
□ Fatigue/Lack of Energy □ Sexual Abuse □ Drug Use
□ Loss of Appetite/Overeating □ Sexual Problems □ Alcohol/Drug Use
□ Trouble Sleeping □ Gender Identity Issues □ Pregnancy
□ Poor Concentration □ Anger □ Abortion
□ Feeling Worthless □ Aggressive Behavior □ Legal Matters
□ Recent Death □ Bad Dreams □ Work Stress
□ Grief □ Unwanted Memories □ Career Choices
□ Chronic Pain □ Loss of Control □ Indecisiveness
□ Loneliness □ Impulsive Behavior □ Parenting Problems
□ Fears □ Control Issues □ Financial Problems
□ Shyness □ Controlled by Others □ Spiritual Problems
□ Low Self-Esteem □ Obsessive Thoughts
□ Other,
Explain:____

____

____

____

____

What do you hope to accomplish from therapy?

____

____

____

____

____

Who would you like to have in your therapy sessions and for what purpose?:____

____

____

Client Signature____Date_____________