



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) _____

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 hospitalized 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 _____