

**Family Life Counseling, P.C.**

6240 S. Main Street, #265

Aurora, CO 80016

Phone: (720) 274-5296 Fax: (720) 274-5267

For office use only

DX:

GAF:

CPT:

Auth:

**Intake Information**Patient Name: \_\_\_\_\_  
Last First Middle InitialPresent Address: \_\_\_\_\_  
Street City State Zip Code

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

May we contact you/leave messages at home?  Yes  NoMay we send you e-mail?  Yes  No

Instructions for phone messages: \_\_\_\_\_

Cell: \_\_\_\_\_

Contact/Messages on cell ok?  Yes  No

Date of Birth: \_\_\_\_\_

Gender:  Male  Female

Relationship Status (single, divorced, married etc.) : \_\_\_\_\_ Spouse: \_\_\_\_\_

Who is responsible for the bill? \_\_\_\_\_

Are you a student?  Yes  No

Name of Primary Insured: \_\_\_\_\_ Date of Birth of Primary Insured: \_\_\_\_\_

Billing address:  Same as above or  \_\_\_\_\_  
 Don't Send Bills Street City State Zip CodeAre you using an Employee Assistance Program (EAP) for sessions?  Yes  No

Name of Insurance/EAP: \_\_\_\_\_

How did you hear about Family Life Counseling, P.C.? \_\_\_\_\_

Employer Name: \_\_\_\_\_ Phone: \_\_\_\_\_

May we call you at work?  Yes  No Instructions for phone messages: \_\_\_\_\_**\*\*\*Who should we contact in case of emergency? \_\_\_\_\_ Phone: \_\_\_\_\_**

## Inventory of Concerns

Identify if you have experienced any of the following in the past month:

- |  |  |
|--|--|
| <p><b>Yes</b></p> <p><input type="checkbox"/> Depressed Mood</p> <p><input type="checkbox"/> Suicidal Thoughts</p> <p><input type="checkbox"/> Appetite Changes</p> <p><input type="checkbox"/> Difficulty Concentrating</p> <p><input type="checkbox"/> Mood Swings</p><br><p><input type="checkbox"/> Tension/Anxiety</p> <p><input type="checkbox"/> Hearing/Seeing Things Others Cannot</p> <p><input type="checkbox"/> Memory Problems</p> <p><input type="checkbox"/> Hostility</p> <p><input type="checkbox"/> Trouble With The Law</p><br><p><input type="checkbox"/> Conflict With Authority</p> <p><input type="checkbox"/> Feeling That You Have Left Your Body</p> <p><input type="checkbox"/> Employment/School Related Difficulty</p> <p><input type="checkbox"/> Family Problems</p> <p><input type="checkbox"/> Abuse (physical, verbal, sexual)</p> | <p><b>Yes</b></p> <p><input type="checkbox"/> Hopelessness</p> <p><input type="checkbox"/> Disturbed Sleep</p> <p><input type="checkbox"/> Significant Weight Loss/Gain</p> <p><input type="checkbox"/> Agitation</p> <p><input type="checkbox"/> Thoughts You Cannot Stop</p><br><p><input type="checkbox"/> Significant Fear</p> <p><input type="checkbox"/> Behavior You Cannot Stop</p> <p><input type="checkbox"/> Feeling That Others Are After You</p> <p><input type="checkbox"/> Violence</p> <p><input type="checkbox"/> Isolation</p><br><p><input type="checkbox"/> Disruptiveness</p> <p><input type="checkbox"/> Desire To Harm Others</p> <p><input type="checkbox"/> Health Problems</p> <p><input type="checkbox"/> Guilt</p> <p><input type="checkbox"/> Marital Conflict</p> <p><input type="checkbox"/> Other: _____</p> |
|--|--|

Have you ever been sexually assaulted/abused?     Yes     No

Have you ever been physically assaulted/abused?     Yes     No

### Social History

List immediate family members (include parents, siblings, children, and other important people):

Family Member	Age	Relationship	Do they live With you? Y/N

Describe any family history of alcoholism, drug use, depression, abuse, suicide, mental illness, or other significant difficulty.

None

Describe any medical problems you have (including allergies).

None

List any medications you currently take.

None

List and describe any past or present therapy or counseling in which you have been involved.

None

### Alcohol Use

Never     Less than 1 time/month     1-4 times per month     2-3 times per week     Daily

Alcohol Consumption Per Use:     None     1-2 Drinks     3-4 Drinks     5 or more drinks

Have you experienced any of the following related to alcohol use?

- |                                   |  |   |   |                                      |
|-----------------------------------|--|---|---|--------------------------------------|
| <input type="checkbox"/> Binges   | <input type="checkbox"/> Job Problems      | <input type="checkbox"/> Sleep Disturbances     | <input type="checkbox"/> Physical Withdrawal    | <input type="checkbox"/> Hangovers   |
| <input type="checkbox"/> Arrests  | <input type="checkbox"/> Blackouts         | <input type="checkbox"/> Medical Complications  | <input type="checkbox"/> Assaults               | <input type="checkbox"/> Passing out |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Inability to stop | <input type="checkbox"/> Interpersonal Conflict | <input type="checkbox"/> Concern about drinking |                                      |



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## Declaration of Custody

(Please complete if client is a child)

I \_\_\_\_\_, attest that I have  
Name of parent/guardian(s)

custody of \_\_\_\_\_, date of birth: \_\_\_\_\_. As such, I have  
Name of client mm/dd/yyyy

full decision-making authority for medical decisions for this individual, and hereby give consent for Family Life Counseling, P.C. and its licensed professionals to provide counseling for this individual.

\_\_\_\_\_  
 Parent/guardian signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Parent/guardian signature

\_\_\_\_\_  
 Date