

Family Life Counseling, P.C.

6240 S. Main Street, #265

Aurora, CO 80016

Phone: (720) 274-5270

Fax: (720) 274-5267

For office use only

DX:

GAF:

Insurance ID:

Auth:

CPT:

Intake InformationPatient 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

School: _____ Grade: _____

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>Yes</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>
<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>
<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>Yes</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>
<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>
<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 | |

What other substances do you use, or have you used in the past **6 weeks** (check all that apply)?

- | | | | | |
|--------------------------------------|-----------------------------------|------------------------------------|-------------------------------------|---|
| <input type="checkbox"/> Cigarettes | <input type="checkbox"/> Caffeine | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Sedatives | <input type="checkbox"/> Hallucinogens |
| <input type="checkbox"/> Cocaine | <input type="checkbox"/> Opiates | <input type="checkbox"/> Inhalants | <input type="checkbox"/> Stimulants | <input type="checkbox"/> Prescription Drugs |
| <input type="checkbox"/> Other _____ | | | | |
| <input type="checkbox"/> None | | | | |

Frequency and Amount Used:

Rank your current problem as you see it:

- | | | | | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Best | | | | | Worst | | | | |
| Ever | | | | | Ever | | | | |

Where would you like the problem to be (i.e. when will you know when counseling is over)?

- | | | | | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Best | | | | | Worst | | | | |
| Ever | | | | | Ever | | | | |

Describe the Problem and Your Goals for Therapy:

****It is highly recommended that you consider a medication evaluation with a physician or psychiatrist if you are struggling with depression, anxiety, or other mental health issue that can be effectively treated with medication.****

Signature of person completing information: _____ Date: _____

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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