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: ____________________ Auth: ____________________

Intake Information

Patient Name:____
Last First Middle Initial

Present Address:____
Street City State Zip Code

Phone:______________________ E-mail:______________________

May we contact you/leave messages at home? ☐ Yes ☐ No May 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
Grade:____ School:______________

Name of Primary Insured:______________ Date of Birth of Primary Insured:__________

Billing address: ☐ Same as above or ☐ ____________________________________
☐ Don’t Send Bills Street City State Zip Code

Are 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:

Yes

- ☐ Depressed Mood
- ☐ Suicidal Thoughts
- ☐ Appetite Changes
- ☐ Difficulty Concentrating
- ☐ Mood Swings

- ☐ Tension/Anxiety
- ☐ Hearing/Seeing Things Others Cannot
- ☐ Memory Problems
- ☐ Hostility
- ☐ Trouble With The Law

- ☐ Conflict With Authority
- ☐ Feeling That You Have Left Your Body
- ☐ Employment/School Related Difficulty
- ☐ Family Problems
- ☐ Abuse (physical, verbal, sexual)

Yes

- ☐ Hopelessness
- ☐ Disturbed Sleep
- ☐ Significant Weight Loss/Gain
- ☐ Agitation
- ☐ Thoughts You Cannot Stop

- ☐ Significant Fear
- ☐ Behavior You Cannot Stop
- ☐ Feeling That Others Are After You
- ☐ Violence
- ☐ Isolation

- ☐ Disruptiveness
- ☐ Desire To Harm Others
- ☐ Health Problems
- ☐ Guilt
- ☐ Marital Conflict

History of:

- Sexual abuse/assault? ☐ Yes
- Physical abuse/assault? ☐ Yes
- Traumatic brain injury/concussion/head injury? ☐ Yes

Social History

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

Family Members' Full Names	Date of Birth	Relationship	Do they live with you? Yes or No – where?

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

☐o 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?

☐ Binges ☐ Job Problems ☐ Sleep Disturbances ☐ Physical Withdrawal ☐ Hangovers
☐ Arrests ☐ Blackouts ☐ Medical Complications ☐ Assaults ☐ Passing out
☐ Seizures ☐ Inability to stop ☐ Interpersonal Conflict ☐ Concern about drinking

What other substances do you use, or have you used in the past **6 weeks** (check all that apply)?
☐Cigarettes ☐Caffeine ☐Marijuana ☐Sedatives ☐Hallucinogens ☐Cocaine ☐Opiates ☐Inhalants ☐Stimulants ☐Prescription Drugs ☐Other___________ ☐None **Frequency and Amount Used:** ____

Rank your current problem as you see it:

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1 Best Ever	2	3	4	5	6	7	8	9	10 Worst Ever

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

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1 Best Ever	2	3	4	5	6	7	8	9	10 Worst 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 custody of
Name of parent/guardian(s)

____, 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 counseling professionals to provide counseling for this individual.

____________________________________ ___________________
Parent/guardian Signature Date

____________________________________ ___________________
Parent/guardian signature Date