6455 N Union Blvd Suite 200
Colorado Springs, CO 80918
voice: 719-761-3217
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Client Intake

Please complete the following information completely in order to provide the best service.

Client Name:			Date:
Date of Birth:	Age:	Sex:	Social Security #:
Mailing Address:			
Physical Address:			
Home Phone:	Cell:		Email:
Guardians:			
Biological Parents:			
Employer/School:			
Paying Agency:		Caseworker/Probation Officer:	
Insurance:			Policy#:
Subscriber Name:		Subscriber Date of Birth:	
Referred by:			
Reason for Referral:			
Previous Mental Health Providers:			
Goals of treatment:			

History

Current Symptoms (Check all that Apply)

☐ Anxiety	☐ Appetite Issues	☐ Avoidance
☐ Depression	☐ Excessive Energy	☐ Fatigue
☐ Hallucinations	☐ Impulsivity	☐ Irritability
☐ Loss of Interest	☐ Panic Attacks	☐ Racing Thoughts
☐ Sleep Changes	☐ Suspiciousness	☐ Crying Spells
☐ Risky Behavior	☐ _____	☐ _____

Medical History

Exercise Frequency	Exercise Type:

Allergies:

Current Medications:

Previous Mental Health Diagnosis:

Dates treated:

Previous/Current Medical Conditions:

Previous Surgeries:

Family History

Were you adopted?	If yes, what age?	Who raised you?

Siblings and Ages:

Family Medical Conditions:

Family Mental Health Conditions:

Life History

Where did you grow up:	How often did you move?
Age when you left home:	Highest level of Education:
Military: / Where:	Dates of Service:
Immediate Family Members Death:	Who:
Any Death by Suicide:	Who:
Neglect suffered:	By Whom:
Abuse:	By Whom:

Present Situation

Work: *Circle one*	Full-Time	Part-Time	Student	Unemployed	Disabled	Retired
Marital Status: *circle one*	Single	Married	Divorced	Widowed	When:	
Children:	Ages:	Children living with you:				
Who Lives with you:						
Legal Involvement:	Dates:					

Alcohol and Drugs

Have you tried any of the following: Circle all that apply:

Alcohol Tobacco Marijuana Hallucinogens(LSD) Heroin Methamphetamines

Cocaine Ecstasy Stimulants (Pills) Methadone Tranquilizers Pain Killers

If yes to any, list dates/frequency of use:			
Treatment for drug/alcohol abuse:	Dates:		
Cigarette use:	Per Day:	Alcohol use:	Drinks Per Week:
Prescription Drug Abuse:	If yes, which ones:		
Signature:	Date:		