DENVER CENTER
FOR
INTEGRATED COUNSELING

CLIENT INTAKE

The information requested in this form will be kept confidential, and will help your counselor to assist you. Please fill out the form as completely as you can. Use an "x" to indicate your choices.

GENERAL INFORMATION

Last Name ____________________________ Middle Initial ___First Name ________________________
Birth Date ___ / __ /_____ Social Security # ____ - ___ - _____ ❑ Male ❑ Female ❑ ______
Street Address ____ Apt # ___________________
City ___________________________ State ______ Zip ___________ Email _________________________
Home # ( ) _______________ Work # ( ) ______________ Mobile # ( ) _______________
Guardian/parent (if under 18) ____
Referred by: ____
Reason for Referral ____
Reason for choosing this Center ____
Religious/denominational preference ____
Your congregation/church/temple ____
Your racial/ethnic identity: ❑ African-American ❑ Native-American ❑ Asian-American
❑ White/Caucasian ❑ Hispanic ❑ Other

EMPLOYMENT/EDUCATION INFORMATION

Full time employee______ Full time at home_____ Part-time employee_______ Unemployed ________
Place of employment ________________________________ Length of Employment _____ Years _____
Type of work you do ____
Highest Level of Education Completed: ❑ High School ❑ College degree ❑ Graduate degree
❑ Professional training ❑ Other ____

FAMILY INFORMATION

Relationships: ❑ Single ❑ Engaged ❑ Married ❑ Separated ❑ Divorced ❑ Widow(er) ❑ Cohabiting
Parents. *Mother*: ❑ living, age _____ ❑ Deceased. *Father*: ❑ living, age ____ ❑ Deceased
Siblings. Number of *Brothers* [ ]. Number of *Sisters* [ ]. ❑ Only Child.
List ages of *Brothers* [ ] of *Sisters* [ ].
Names and ages of your *Children*: ____
____
____

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1) Have you (now or ever) experienced or witnessed a traumatic event? Briefly describe _____________
____
2) Have you (now or ever) experienced verbal abuse? ____
physical abuse? ______________________________ sexual abuse? ___________________________
3) Have you ever had any legal incarcerations? ______________ convictions? __________________
4) Have you ever been hospitalized for psychiatric treatment? ______ When? _________ # times ___

PROBLEM DEFINITION

What is your reason for seeking help now? ____

____

____

Are any of the following conditions a problem to you at this time? (Check the ones that apply)

___Anger
___ Anxiety
___Chronic fear
___Communication
___Concentration
___Conflicts at work
___Depression
___Domestic Abuse
___Eating Disorder
___Financial
___Gaming
___Grief/Loss
___Guilt

___Helplessness
___Irrational fears
___Loneliness
___Loss of faith in God
___Loss of hope
___Loss of meaning in life
___Loss of work/job
___Marriage problems
___Memory
___Mood Swings
___Nervousness
___Obsessive Thoughts
___Partner Conflict

___Parenting
___Pornography
___Rage
___Relationship to children
___Relationship to parents
___Religious doubts
___Self esteem
___Sexual problems
___Sibling Conflict
___Sleep Issue
___Stress
___Substance abuse
___Suicidal feelings

What would you like to see happen as a result of psychotherapy or counseling?

____

____

MEDICAL/PSYCHOLOGICAL HISTORY

Name and address of your physician: ____

____

When was your last medical examination? ____

Are you suffering any physical illnesses or symptoms at this time? ______________________

____

List major surgeries or illnesses in the last five years: ______________________________

____

____

List current medications: ____

____

Have you or any member of your family received help for drug or alcohol dependency? ❑ Yes ❑ No

When? ________________ Name of helping agency ______________________________

Have you received psychotherapy or counseling in the past? ❑ Yes ❑ No. When? ____________

Name of treating therapist: ____

Make a check mark if any of these statements are true:

- ❑ Do you have thoughts of harming yourself or others?
- ❑ Are thoughts of harming yourself or others a frequent occurrence?
- ❑ Do you dwell on these thoughts and wonder if you can control them?
- ❑ Have you sought professional help because of these thoughts or feelings?

ACKNOWLEDGEMENT Please sign and date this document attesting that the information you have written on this form is accurate to the best of your knowledge.

____ ______________________________

CLIENT'S SIGNATURE DATE