Creative Counseling Center, LLC
6021 S. Syracuse Way Suite 216
Greenwood Village, CO 80111
303.843.6000

Client Information

Name(s): _____ Date: _____

Parent/Guardian (if minor child): _____ Date of Birth: _____ Age_____

Address:_____ Telephone: (_____) _____

City/State/Zip: _____ Cell: (_____) _____

Email:_____ Add to Newsletter? □Yes □No

Marital Status: Single___ Engaged___ Married___ (How Long? _____)

Separated___ (How Long_____) Divorced___ (How Long _____)

Life Style: Living alone____ Living with family____ Living with non-family____

Living Situation: House, Hotel, Room, Apartment, etc.?_____

Employment Status (employed/unemployed)_____Occupation _____

Employer _____ Work Telephone (____) _____

Fee/session _____

Reason(s) for Service:

_____

Referral Source (if applicable):

_____

Person responsible for paying for your psychotherapy

Their relationship to you_____ Telephone (____)

Chief Concern/Presenting Problem

Have you (or spouse) ever been involved in therapy/counseling programs? ___Yes ___No
If yes, When:_____ Where:_____
Reasons: _____
How did it go/likes/dislikes:_____

Are you in treatment with another counselor at this time? ___Yes ___No
If yes, with whom? _____
When? _____ How long? _____

What is troubling you that you are seeking therapy at this time?

When did this concern begin to be a problem for you? What is your sense of why you have began to have this problem, especially at this time? What else is going on in your life that may be related to the beginning of this concern?

Have you experienced a similar concern at any other time? When? What helped you to get better?

Medical and Drug History

Are you or have you ever been on medication for an emotional or mental problem? When?

Medication	Dosage	Prescribing MD	Condition

What other prescription or non-prescription medications do you take? (Include caffeine, nicotine, sugar, ect) How much/often?

Have you ever been hospitalized for an emotional or mental problem? If so, please explain.

Have you ever been treated for drug or alcohol use? (Dates/facilities) .....Yes .....No

Do you currently use alcohol or drugs? .....Yes .....No

Alcohol/drugs	Use	Frequency (days/week)	Amount
Beer	Yes No	1 2 3 4 5 6 7	
Wine	Yes No	1 2 3 4 5 6 7	
Hard Liquor	Yes No	1 2 3 4 5 6 7	
Marijuana	Yes No	1 2 3 4 5 6 7	
Cocaine	Yes No	1 2 3 4 5 6 7	
Amphetamines	Yes No	1 2 3 4 5 6 7	
Narcotics	Yes No	1 2 3 4 5 6 7	
Diet Pills	Yes No	1 2 3 4 5 6 7	
Other	Yes No	1 2 3 4 5 6 7	

If you not currently use alcohol or drugs, did you use in the past? .....Yes .....No

Alcohol/drugs	Use	Frequency (days/week)	Amount
Beer	Yes No	1 2 3 4 5 6 7	
Wine	Yes No	1 2 3 4 5 6 7	
Hard Liquor	Yes No	1 2 3 4 5 6 7	
Marijuana	Yes No	1 2 3 4 5 6 7	
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Amphetamines	Yes No	1 2 3 4 5 6 7	
Narcotics	Yes No	1 2 3 4 5 6 7	
Diet Pills	Yes No	1 2 3 4 5 6 7	
Other	Yes No	1 2 3 4 5 6 7	

Client and Family History:

Have any of the following events occurred in your life in the past year? (check all that apply)

n Death of a friend/family member
n Change in close personal relationship (e.g. divorce, separation)
n Serious problem with friend/family member
n Personal injury, illness or accident or Family injury, illness or accident
n Major change in employment status
n Serious job-related difficulties
n Accused of a crime/victim of a crime
n Major geographic relocation
n Sexual/physical abuse or rape
n Marriage
n Birth of a child/Abortion/Miscarriage
n Surgery/Medical problems
n Legal problems
n Financial problems
n Other: _____

Have you ever experienced:

Type of abuse	Incidence?	By Whom?	How often?	What age(s)?
Physically abused	Yes No			
Sexually abused	Yes No			
Emotionally abused	Yes No			
Severely disciplined	Yes No			
Witnessed DV	Yes No			

Have you ever:

	Incidence?	# of times/How often	What age(s)?
Attempted suicide	Yes No		
Attempted Homicide	Yes No		
Committed Homicide	Yes No		

Have you or any of your family had a history of:

Problem area	Client Hx	Family Hx	Who in family	Side of family
Alcoholism	Yes No	Yes No		Father/mother
Drug abuse	Yes No	Yes No		Father/mother
Eating disorders	Yes No	Yes No		Father/mother
Depression	Yes No	Yes No		Father/mother
Bipolar disorder	Yes No	Yes No		Father/mother
Anxiety	Yes No	Yes No		Father/mother
Physical disability	Yes No	Yes No		Father/mother
Obesity	Yes No	Yes No		Father/mother
Schizophrenia	Yes No	Yes No		Father/mother
Physical abuse	Yes No	Yes No		Father/mother
Sexual abuse	Yes No	Yes No		Father/mother
Emotional abuse	Yes No	Yes No		Father/mother
Severe trauma	Yes No	Yes No		Father/mother
Suicide	Yes No	Yes No		Father/mother
Homicide	Yes No	Yes No		Father/mother

Tell me about the relationships in your current family:

Tell me about the relationships you had with your parents/life growing up:

Tell me about school/work:

Please list everyone in your family with whom you presently live with (names/ages):

_____ _____
_____ _____
_____ _____
_____ _____

What are your strengths?
Skills:
Interests:
Resources:
Qualities:

What do you expect from therapy?

Client/Family goals for therapy? (specific and measurable)

Anything else of significance that I have left out or have not asked?

If you are a victim of a reported crime or qualify for victim compensation, please complete the following questions.

- Describe the victimization.

- Date of crime?
- Frequency/duration of the crime?

- Name of the perpetrator?
- Reporting law enforcement agency?
- What was the initial disclosure & who was it initially told to?

- How was the person functioning prior to the crime?

- What is the current behavior and emotional symptoms directly related to the victimization?