Laurie Branch, LPC
3445 Penrose Place Suite 250
Boulder, CO 80301

Personal Intake Form

This confidential information is for use by your counselor. Each person coming for counseling should fill out a form. Please complete both sides and PRINT all information clearly.

Date: ______________________ Social Security #:_____________________

IDENTIFICATION DATA:

First/Last Name:____

Address:____

City:___________________________ State:_____ Zip:___

Gender:_____________ Birth date:___________ Age:______ Race:_______

Occupation:_____________________________Employer:________________

Work phone:_____________________Home phone:______________________

Email address:_____________________________

If under 18, name of parent/guardian:___________________________________

Emergency Contact (name/phone/address): _____________________________

If student, name of school (incl. major/degree if applicable):___________________

How much education have you completed?______________________________

Other training (list type and years):____________________________________

____

MILITARY HISTORY:

List branch of service and years:__________________ Served in combat?_______

RELATIONSHIP INFORMATION: Sexual orientation: ______________________

Status (circle):

Single/Never Married In a Committed Partnership Engaged

Married (1st time) Remarried Single/Divorced

Separated Living with Partner Widowed

Name of partner:____

Partner's Age: _______ Partner's Gender: _________

Partner's Address: ____

Partner's Phone: ___________________ Partner's Education Level: _______________

Partner's Occupation: _______________________Partner's Employer:______________

Is Partner willing to come to therapy? ______ Length of this relationship: ____________

Are you married? ____________ When did you marry?__________________________

Your ages when married: You_______ Partner________

Please give information about previous marriages. Include dates of marriage, dates of dissolution, and whether ended in divorce or death: _____________________________

____

____

FAMILY INFORMATION:

List your biological children with names/ages): _________________________________

____

List your other children: step (SC), adopted (AC), or foster (FC) with names/ages:

____

____

Were you reared by your biological parents? ____ Yes ____ No

If No, please explain____

____

Are your parents still married? ____Yes ____No

If not, please explain & list your age at marriage dissolution:______________________

____

SPIRITUALITY INFORMATION:

Do you consider yourself a spiritual person? ____Yes ____No ____ Uncertain

Spiritual Affiliation: Present____________________ Past ________________________

If you currently attended services, please list where: _____________________________

HEALTH INFORMATION:

Current/chronic medical conditions: ____

____

Recent weight changes/list amount gained or lost: _______________________________

Serious illnesses/injuries/traumas: ____

____

Hospitalizations or surgeries: ____

____

List current medications/dosages: ____

Doctor's name/address/phone: ____

____

Have you ever had counseling before? ____No ____Yes When?___________________

For how long? ____________________ For what conditions? _____________________

Counselor's name/address/phone: ____

____

FOR TREATMENT PLANNING:

Type of counseling desired: ___Individual ___Marital ___Family ___Group ___Other

What is the concern that motivated you to seek therapy? _________________________

____

____

____

For those areas that apply to you, please rate how much distress you feel related to this issue on a regular basis, with 0 being no distress and 10 being extremely distressful.

_______ Depression

_______ Suicidal Thoughts

_______ Suicidal Actions

_______ Cutting/Self-Mutilation

_______ Anxiety

_______ Panic Attacks

_______ Sleep Problems

_______ Disordered Eating

_______ Withdrawn Behavior

_______ Health Problems

_______ Job-related Problems

_______ Financial Concerns

_______ Domestic Violence

_______ Parent-child conflict (self)

_______ Parent-child conflict (other)

_______ Communication problems

_______ Spiritual health

_______ Work addiction

_______ Porn addiction

_______ Sex/masturbation addiction

_______ Internet addiction

_______ Alcohol/drug use (self)

_______ Alcohol/drug use (other)

_______ Relationship problems

_______ Sexual problems

_______ Physical abuse

_______ Legal difficulties

_______ Death of a loved one

_______ Gambling

_______ Self-esteem

_______ Career choice concerns

_______ Sexual abuse, actual

_______ Sexual abuse, threatened

_______ Sexual assault/rape

_______ Sibling issues

_______ Blended family issues

_______ Parental loss of control

_______ Gender identity issues

_______ Sexual orientation issues

_______ Rage (i.e., road rage)

_______ Anger issues

_______ ADD/ADHD

_______ Other ____

What goals do you hope to accomplish in therapy? ______________________________

____

____

____

Is there anything else I should know about you that might help influence the counseling process?

____

____

____

REFERRAL

Referred by: _________________________________ Relationship: _____________________

May I thank this person for the referral?____