North Cherry Creek Counseling Center

Thank you for selecting North Cherry Creek Counseling Center. We will strive to provide you with the best possible care. To help us meet your needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us. All information, which you provide us, is strictly confidential.

Date:_____ Referred by:_____

Client Name: _____ DOB: _____

Address:

_____

City:_____ State: _____ Zip: _____

It is important for you to understand that any means of communication is not without security issues. Email and phones messages are not secure and it is important that you have say in regards to the privacy of your information – Please indicate and Sign that you approves of these means of communication to convey both logistics and therapy content.

Email address:_____

Home Phone ( )_____ OK to leave message Y N

Work Phone ( )_____ OK to leave message Y N

Cell Phone ( )_____ OK to leave message Y N

I approve of these means of communication for both therapy logistics (appointment times) and content (homework and check in.) Logistics Y N Content Y N

Signature: _____

Employer Name & Address:_____

Gender: M F
Religious Affiliation:_____

Marital Status: (circle the applicable answer) How Long:_____

Single Engaged Married Remarried Separated Divorced Widowed

Spouse's Name:_____
(or Parent's Name, if minor)

DOB:_____

Home Phone ( )_____ OK to leave message Y N

Work Phone ( )_____ OK to leave message Y N

Cell Phone ( )_____ OK to leave message Y N

Spouse's/Parent's Employer & Address

_____

_____

Emergency Contact:_____

Their Daytime Phone ( ) Evening Phone ( )

Current Physician & Phone #:

Current Medications:

List all previous therapists and counseling experience:

Have you formally terminated therapy with your previous therapist? Yes ( ) No ( ) N/A ( )

If yes, are you willing to sign a release of information? Yes ( ) No ( )

Family History:	Age or Date of Death	Health	Relationship positive or negative
Natural Mother			
Natural Father			
Step-Mother			
Step-Father			
Siblings			
Children:			

Has ANYONE in your family experienced any of the following:
(check any which are appropriate)

___schizophrenia
___depression
___mood swings
___anxiety/panic attacks
___suicide or attempt
___sexual abuse
___physical abuse
___alcohol abuse
___drug abuse
___imprisonmen
___learning disability
___attention deficit

___mental retardation
__dementia/brain damage

Symptom & problem list: Check any which apply to you:

___no energy
___cannot enjoy life
___memory problems
___anxiety
___fatigue
___anger outbursts
___shortness of breath
___sweating
___hot flashes
___relives past event
___no loving feelings
___fears
___chest pains
___decisions difficult
___racing thoughts
___foolish business investments
___hard to make friends
___work problems
___out of control behavior
___take pain killers often
___mood swings
___unusual experiences
___physical numbness
___panic attacks
___vomiting
___miscarriage
___impaired vision
___back pain
___drug use
___insomnia
___disturbing memories
___low self-esteem
___poor appetite
___headaches
___nightmares
___heart palpitations
___clammy hands
___startles easily
___flashbacks
___hopeless feelings
___sexual difficulties
___suicidal thoughts
___overly confident
___distractibility
___sexual indiscretions
___socially withdrawn
___eating disorder
___drinking alcohol
___seeing things
___excess energy

___unsure of reality
___wish to die
___confusion
___weight change
___abortion
___impaired hearing
___muscle spasms
___tremors
___depressed
___guilt feelings
___poor concentration
___overeating
___dizziness
___unwanted thoughts
___racing heart
___stomach problems
___sleeps too much
___always on guard
___apathetic
___numbing out
___distrustful
___pressured speech
___buying sprees
___high risk activities
___family arguments
___often physically sick
___hearing voices
___losing track of time
___slowed thinking
___physical violence
___unsure of identity
___seizures
___pregnancy
___sporadic dieting
___blackouts/fainting
___hypertension
___hallucinations

Briefly describe why you have come and what you hope to accomplish from therapy:

How long has this been a need or an issue?

When is it better or worse?

Who can or does support you in the change process?

Anything else you would like to let me know or you think would be helpful to our time together: