Colorado Counseling Professionals, P.C.

Client Information Form

Today's Date: _____ **Date of Birth**: _____/_____/_____

Name: Last_____ First_____ M.I._____

Address: Street_____

City: _____ State:_____ Zip Code:_____

Home Phone:_____ **e mail Address**:_____

Cell/Pager:_____ May we call home? _____Yes _____ No

May we leave a message? ___ Yes ____ No Which number do you prefer us to call? (circle one)

Is it ok to text or email you? ___ Yes ____ No **Social Security** #:_____-_____-_____

Health Insurance (if utilizing): _____

Member ID#_____ **Phone # on card**:_____

In Case of Emergency : Contact_____ Phone #:_____

Employed:___Yes___No Hours/Week:_____ Position/Company_____

Have you used our services before?____Yes____No

How did you find us? _____

Have you had previous counseling? ____Yes____No With Whom?_____

When _____ For how long?_____

Marital Status: ___Married ___Divorced ___Partnered ___Separated ___ Single ___ Widowed

Family Members:	Name	Age	Occupation
Father			
Mother			
Brother(s)			
Sister(s)			
Children			
Partner/Spouse			

My family has a history of: Please check all that apply

___Counseling ___Substance Abuse ___Psychiatric Hospitalization ___Abuse
___Depression ___Eating Disorders ___Suicidal Behavior

Your Counseling Concerns/Goals: _____
_____
_____
_____

Concerns/Symptoms: Please check any areas that are a concern for you now.

___Academic
___Career
___Self-esteem
___Relationships
  ___Family
  ___Spouse/Partner
  ___Friend(s)
  ___Others
___Depression
___Anxiety
___Health/Physical Disability
___Legal
___Financial
___Death or Impending Death
___Substance use/abuse
  ___Alcohol
  ___Drugs
  ___Other

___Abuse
  ___Physical Violence
  ___Emotional/Verbal Abuse
  ___Abused as a child
  ___Rape/Sexual Assault
___Harm to Others
  ___Desire/Plan to harm
  ___Assaulted someone else
  ___Other
___Harm to Self
  ___Thoughts/Plan
  ___Suicide Attempt
  ___Other Self-inflicted Injury
___Grief/Loss
___Eating Disorder
  ___Anorexia
  ___Bulimia
___Other Concerns: _____

Missed Appointments:
Clients who forget their appointments or cancel less than 24 hours prior to their session in the absence of a real emergency will be charged $35.00 for that session. Exceptions to this policy include valid emergencies and illnesses. Please initial that you understand the above policy and agree to the terms as outlined.

Client initials _____ Date _____