DENVER BOULDER
COUNSELING

Kelly Shaughnessy, MA, LPCC

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SUITE 100-D

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http://denverbouldercounseling.com

DATE	
IS THIS A PREVIOUS PATIENT?	
REFERRED BY (friend, therapist, google, psychology today, etc)	

PATIENT INTAKE INFORMATION

NAME			
CELL PHONE		**HOME ADDRESS**	
ALT. PHONE			
EMAIL			
SOCIAL SECURITY NUMBER		**WORK ADDRESS**	
DATE OF BIRTH			

EMERGENCY CONTACT

NAME OF CONTACT		**RELATIONSHIP TO CLIENT**	
MAIN PHONE #		**ALT. PHONE #**	

HEALTH INFORMATION

Describe the reason for the initial visit.

HOW OFTEN DO YOU EXERCISE?		**WHAT PRESCIRTIONS ARE YOU TAKING?**	
DO YOU HAVE ANY ALLERGIES?		**HOW WOULD YOU RATE YOUR SLEEPING HABITS?**	

Describe your physical health in general.

Please circle any of the following conditions you've had a health issue with.

anemia	arthritis	anxiety	broken bone
chronic back pain	bladder trouble	poor circulation	measles
cancer	chest pain	sinus trouble	hepatitis
convulsions	high blood pressure	asthma	tuberculosis
seizures	kidney trouble	indigestion	neck pain
migraines	heart trouble	dermatitis	diabetes
osteoporosis		epilepsy	artificial joints

Please elaborate on any conditions circled above.

Describe your mental health in general.

Please circle any of the following conditions you've had a health issue with.

anxiety	eating disorders	financial problems
depression	parents	head injuries
anger	children	nausea
concentration	sleeping	attention
phobias	child abuse	trust in others
communication	sex abuse	worry
drugs/alcohol	nightmares	self-inflicted pain

Please elaborate on any conditions circled above.

CLIENT SIGNATURE

DATE