# Grand Junction Counseling, LLC – *“Your Pathway to Peace!”*

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115 North 5th, Suite 401 Grand Junction, CO 81501 Phone: 970-640-2428 Email: [StephenFAnthony@yahoo.com](mailto:StephenFAnthony@yahoo.com)

**Confidential Client Intake Form**

\*Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*May I contact you by email for scheduling purposes?

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Can I call you here? \_\_\_\_\_\_ Can I leave a message? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Can I call you here? \_\_\_\_\_\_ Can I leave a message? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*What is the best number to reach you at? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Occupation/Work History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Single \_\_\_\_\_, Dating \_\_\_\_\_\_, Engaged \_\_\_\_\_\_, Married/Partnered \_\_\_\_, Separated \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Divorced \_\_\_\_\_, Remarried \_\_\_\_\_\_, Widowed \_\_\_\_\_\_\_, Living together \_\_\_\_\_, Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Others living in the home (Names, Ages, Relationship):

**\*What brings you to counseling at this time?**

**\*What are your goals for therapy?** (i.e., if therapy is successful, what are you hoping will be different about your life?)

**\*What are your strengths that will assist you in reaching your goals?**

\*Person to contact in case of emergency (name and phone):

\*If someone other than the client is responsible for payment, please provide the following information:

Name of Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

That Party’s Contact Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*How did you find out about my services?

\*Has anyone urged you to start counseling?

\*Type of counseling requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (individual, couple, family, group)

\*Would you be interested in a counseling group? \_\_\_\_\_\_\_\_\_\_ For what issues/topics\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Have you ever been to counseling before? Yes \_\_\_ No \_\_\_\_ If yes, When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Name and location of therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Give a brief description of issues worked on:

\*Primary Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*List any significant health problems:

\*Describe how you feel about your body and general health:

\*Are you currently under medical care? Yes \_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, then please explain/describe.

\*Are you currently taking prescribed medications? Yes \_\_\_\_\_\_ No \_\_\_\_

If yes, then please explain/describe.

\*Have you ever been in a drug alcohol or other treatment program? Yes \_\_\_\_\_ No \_\_\_\_\_

When? Where? For what reason? Outcome?

Have you ever been hospitalized for physical or mental health issues? Yes\_\_\_\_ No \_\_\_\_\_ (If you feel comfortable, briefly describe).

Have you ever attempted or considered suicide? Yes \_\_\_\_\_ No \_\_\_\_\_ (If you feel comfortable, briefly describe).

List any psychiatric/mental health medications you have taken, or are currently taking:

Does anyone in your family have a history of mental/physical health issues? Who? What type?

What kind of support system do you have?

*Please circle any current or past issues that still affect you:*

Anxiety Depression Fears/Phobias Eating Disorders

Sexual Problems Suicidal Thoughts Separation/Divorce Academic Issues

Finances Drug/Alcohol Use Career Choices Anger

Self-Control Unhappiness Insomnia Spiritual Concerns

Work/Stress Health Problems Cutting/Self-Mutilation

\*Death of someone close

Recently (when: \_\_\_\_\_\_\_\_\_\_)

In the past (when: \_\_\_\_\_\_\_\_\_)

\*Childhood Abuse

(i.e. physical? \_\_ sexual? \_\_\_ emotional? \_\_\_\_)

\*Sexual Assault/Rape

Recently (when: \_\_\_\_\_)

In the past (when: \_\_\_\_)

\*Family Issues (i.e. divorce, alcoholism, domestic violence)

\*Relationship Concerns

Family

Friend

Parent

Significant Other

Roommate

**If you currently experience any of the following symptoms, please rate them using the key below:**

0= Never 1=Seldom 2=Often 3=Always

Difficulty Concentrating \_\_\_\_ Anger \_\_\_\_

Crying \_\_\_\_ Negative thoughts about body \_\_\_\_

Missing classes \_\_\_ Eating binges \_\_\_\_

Feeling uptight\_\_\_\_ Restricted food or not eating \_\_\_\_

Worrying \_\_\_\_ Drinking heavy \_\_\_\_

Feeling hopeless \_\_\_\_ Other drug use \_\_\_\_

Feeling afraid \_\_\_\_ Guilt feelings \_\_\_\_

Lying to others \_\_\_\_ Withdrawling socially \_\_\_\_

Feeling out of control \_\_\_\_ Sexual preoccupation \_\_\_\_

Feeling self-doubt \_\_\_\_ Stealing \_\_\_\_

Memory loss or blackout \_\_\_\_ Difficulty sleeping \_\_\_\_

Physical symptoms (e.g., headaches, digestive)

List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen a health care provider for these?

PLEASE SIGN AND RETURN TO THERAPIST

By signing this document I certify that I am the client or am duly authorized to furnish this information. I understand that I am responsible for all charges whether paid by insurance or not. I also authorize the release of any information by the therapist necessary to secure payment of fees.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_