Big Spring Counseling, LLC
10200 E. Girard Ave., Suite B-222
Denver, CO 80231

New Client Intake

Personal Information

Name: ____Date:________________________

Address:____

City:_______________________________________State:______________Zip:______________________________

Home phone:____________________ Work Phone:______________________ Cell:__________________________

E-Mail address:_________________________________

Birthdate:________________________________Age:________________________Sex:_______________________

Marital Status:____________________________ Spouse's Name:____

How were you referred?____

Whom should we contact in case of emergency?____

Education/Occupation

Employer:____________________________________Position:____

Highest educational
grade level completed:____Major:______________________________

Trade School or Special Program:____

Current Occupation:___________________________________

Medical and Counseling History

Have you ever consulted a therapist before?____________________ If yes, please complete following information.

Name of therapist	When seen and for how long	Major issues discussed

Any medical problems we should know of?____

Have you been, or are you now, taking any medications?____

If so, please list medications and dosage:____

____

Family Information

	Names	Age	Mental Health Issues?
Spouse	____________________	______	____________________
Children	____________________	______	____________________
	____________________	______	____________________
	____________________	______	____________________
Parents	____________________	______	____________________
Siblings	____________________	______	____________________
	____________________	______	____________________
	____________________	______	____________________

Personal History

Please indicate any of the following that you have experienced:

- ☐ ADHD/ADD
- ☐ Adoption
- ☐ Alcohol/Substance Misuse
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Child Abuse/Neglect
- ☐ Chronic Pain
- ☐ Depression
- ☐ Domestic Violence
- ☐ Eating Disorders
- ☐ Obesity
- ☐ Obsessive Compulsive Behavior
- ☐ Schizophrenia/Schizoaffective Disorder
- ☐ Sexual Assault

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☐ Sexual Issues

☐ Suicide Attempt

Daily Rhythms

How would you rate the quality of the following?

Sleep	Poor	Fair	Good
Appetite	Poor	Fair	Good
Mood/Emotional Regulation	Poor	Fair	Good
Self-Awareness	Poor	Fair	Good
Physical Health	Poor	Fair	Good
Exercise	Poor	Fair	Good
Family Support	Poor	Fair	Good
Friend Support	Poor	Fair	Good
Career/School	Poor	Fair	Good
Significant Other Support	Poor	Fair	Good
Spiritual/Religious life	Poor	Fair	Good

What do you consider to be some of your strengths?

____

____

____

What do you consider to be some of your weaknesses?

____

____

____

What would you like to accomplish during your time in therapy?

____

____

____

____

Billing Information

Who is responsible for payment?____

Social Security Number: ______________________ Medicaid #____________________

Name:____

Billing Address:____

____

Phone Number:____

Email address:____

Relationship to client:____