Highline Counseling Group
Carol Selander

Cherry Creek Office
1400 S Colorado Blvd #410 (Lewan Building)
Denver, CO 80122

Littleton Office
8 W Dry Creek Cir, Ste 208
Littleton, CO 80120

Main Phone: (303)321-1113 Fax: (303)757-7275

Thank you for selecting Highline Counseling Group. 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. The information you provide in this intake form may be confidential; however, certain otherwise confidential information may be shared as required by law. You are not required to supply the information contained in this Intake Form. Please provide as much information as possible. Any request or authorization in this form to contact a Third Party, such as a medical doctor, will require a separate Authorization for Release of Information.

INTAKE FORM FOR ADULT

Client Information:
Client's Name: ____

Gender: ☐Male ☐ Female Client's Birthdate: ____________________

Client's Address: ____

City: _________________ State:_____________ Zip Code: __________

May Carol contact you at this address: ☐ YES ☐ NO

Home Telephone: ___________ Cell Phone: ____________Work Phone: _____________

May Carol contact you at all the above telephone numbers provided: ☐ YES ☐ NO
____

May Carol leave a voice message at all the above telephone numbers provided: ☐ YES ☐ NO
____

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Email Address: _________________________ Do you share this email address with anyone else? If so please list who else shares the email address: _____________________________________

May Carol contact you at the above email address: ☐ YES ☐ NO

**Please be aware there is a risk that an unintended third-party may access information shared by electronic transmissions such as email and cell phone. By allowing Carol to contact you by email you are consenting to receive electronic communications and understand the risks involved. Carol cannot guarantee that confidential information shared using electronic communications will remain confidential.

What is your preferred method of communication:

□Telephone (H) □ Cell Phone, including texts □ Telephone (W) □ Email

Client's Occupation: ____

Number of Months at this Occupation: ____

Marital Status: ☐ Single ☐ Married or Civil Union ☐ Separated ☐ Divorced ☐ Living Together

Do you have any children: ☐ YES ☐ NO How many? _________ Ages:_____________________

It is the policy of Carol not to treat any of your children while providing mental health services to you. It is not within Carol's scope of practice to provide recommendation for custody arrangements.

Religious Affiliation:____________________

Church Attending:__________________________ How long?_____________

Do you desire for your faith/spirituality to be part of your counseling process? ☐ YES ☐ NO

Emergency Contact Information:

In case of an emergency, Carol may be required to contact someone on your behalf. Please list your emergency contact below, which she may contact on your behalf. She will only share the minimum amount of information necessary with your emergency contact should he or she need to be contacted.

Name: ____

Telephone Number: ____

Relationship to Client: ____

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Primary Care Physician Information:

In order to provide you with continuous and congruent care, Carol may need to contact your primary care physician. Any contact that she may have with your Primary Care Physician will require you to sign an Authorization for Release of Protected Health Information and Confidential Information.

Name: ____

Telephone Number: _________________________ Fax: ___________________________

Address: ____

Please Provide the Date of Your Last Physical: ____

May Carol contact your physician: ☐ YES ☐ NO

Please list any medication you are currently taking (if you are not currently taking any medications, please state that you are not currently taking any medications):

Previous/Current Mental Health Provider(s):

In order to provide you with continuous and congruent care, Carol may need to contact your previous or current Mental Health Provider. Any contact that she may have with your previous or current Mental Health Provider will require you to sign an Authorization for Release of Protected Health Information and Confidential Information.

Name: ____
Telephone Number: _________________________ Fax: ___________________________
Address: ____ Please Provide the Date of Your Last Session: ____

May Carol contact your previous or current Mental Health Provider: ☐ YES ☐ NO

Are you currently in counseling with the above listed mental health provider: ☐ YES ☐ NO

Have you ever sought counseling before: ☐ YES ☐ NO

If yes, please list your reason(s) for seeking mental health services (if you are currently seeing another mental health provider, please list the reason(s) here as well):

Client's Mental Health:

Please tell us why you are seeking counseling and describe any issues/problems that led you to seek counseling:

How have you dealt with these issues/problems in the past:

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Please list any past or current psychological illnesses or other mental health issues:

Have you ever been, or are you currently, suicidal:

Have you ever attempted to commit suicide:

Has anyone in your family ever attempted or committed suicide:

Have you used, or do you currently use, alcohol, inhalants, nicotine products, marijuana, or any illegal drugs (if so, please indicate which ones):

Are you currently involved in any civil or criminal legal proceedings: ☐ YES ☐ NO
If yes, please state the circumstance(s):

Is there anything else you would like Carol to know:

What would you like to accomplish through therapy and/or what goes would you like to achieve?

Financial Information:

1. Do you intend on using insurance benefits to pay for counseling services: ☐ YES ☐ NO

If yes, please list your insurance company: ____ **a copy of your insurance card is needed for your file

Will you need receipts for your insurance company: ☐ YES ☐ NO

2. Do you intend on a third-party (besides an insurance company) paying for counseling services: ☐ YES ☐ NO

If yes, please provide the following information:

Name: ____

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Telephone Number: ___________________________ Fax: _____________________________

Address: ____

Relationship to Client: ____

3. Do you intend on paying for counseling services on your own: ☐ YES ☐ NO

Checklist of Concerns:

Please mark all of the areas of concern below that apply to you. You may add a note or details in the space next to the concerns checked.

CONCERN	NOTES	NOW	IN THE PAST
Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals			
Aggression, violence			
Alcohol use			
Anger, hostility, arguing, irritability			
Anxiety, nervousness			
Attention, concentration, distractibility			
Career concerns, goals, and choices			
Childhood issues (your own childhood)			
Codependence			
Confusion			
Compulsions			
Custody of children			
Decision-making, indecision, mixed feelings, putting off decisions			
Delusions (false ideas)			
Dependence			
Depression, low mood, sadness, crying			
Divorce, separation			

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Drug use—prescription medications, over-the-counter medications, street drugs			
Eating problems—overeating, undereating, appetite, vomiting, (see also "Weight and diet issues")			
Emptiness			
Failure			
Fatigue, tiredness, low energy			
Fears, phobias			
Financial or money troubles, debt, impulsive spending, low income			
Friendships			
Gambling			
Grieving, mourning, deaths, losses, divorce			
Guilt/Shame			
Headaches, other kinds of pains			
Health, illness, medical concerns, physical problems			
Housework/chores—quality, schedules, sharing duties			
Inferiority feelings			
Interpersonal conflicts			
Impulsiveness, loss of control, outbursts			
Irresponsibility			

Judgment problems, risk taking			
Legal matters, charges, suits			
Loneliness			
Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments			
Memory problems			
Menstrual problems, PMS, menopause			
Mood swings			
Motivation, laziness			
Nervousness, tension			

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Obsessions, compulsions (thoughts or actions that repeat themselves)			
Oversensitivity to rejection			
Pain, chronic			
Panic or anxiety attacks			
Parenting, child management, single parenthood			
Perfectionism			
Pessimism			
Procrastination, work inhibitions, laziness			
Relationship problems (with friends, with relatives, or at work)			
School problems (see also "Career concerns ...")			
Self-centeredness			
Self-esteem			
Self-neglect, poor self-care			
Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")			
Shyness, oversensitivity to criticism			
Sleep problems—too much, too little, insomnia, nightmares			
Smoking and tobacco use			
Spiritual, religious, moral, ethical issues			
Stress, relaxation, stress management, stress disorders, tension			
Suspiciousness, distrust			
Suicidal thoughts (You or a relative)			
Temper problems, self-control, low frustration tolerance			
Thought disorganization and confusion			
Threats, violence			
Weight and diet issues			
Withdrawal, isolating			

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Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition			

❑ Other concerns or issues:

Family History:

	Age or Date of Death	Health
Natural Mother	_______	__________
Natural Father	_______	__________
Step-Mother	_______	__________
Step-Father	_______	__________
Siblings: (sisters, brothers)		
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 attempts
___sexual abuse
___physical abuse
___alcohol abuse
___drug abuse
___imprisonment
___learning disability
___attention deficit
___mental handicap
___dementia/brain damage

Any Other Family history that you would want me to know?

Client Affirmation:
By signing this Intake Form, I certify that all the information is true and accurate to the best of my knowledge.

_____________________________ Client Signature

________________ Date

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