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Confidential Intake Form

Date: _____

BASIC INFORMATION

Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work _____ Cell _____

At which number do you prefer to be contacted? _____ Email: _____

Date of Birth _____ Age _____ M F

MARITAL STATUS

Single Married for _____ years/months. I have been married _____ times.

Divorced for _____ years/months after a marriage of _____ years.

Separated for _____ years/months after a marriage of _____ years.

Widowed for _____ years/months after a marriage of _____ years.

Name of spouse (if currently married) _____ Age _____

Names and ages of Children (if any): _____

EDUCATION AND OCCUPATION

Current Student? Yes _____ No _____ Current Occupation _____

Highest degree or year of schooling obtained and major _____

LEGAL HISTORY

Are you now or have you been in past legal trouble? Yes _____ No _____

If yes, briefly describe: _____

Are you now or have ever been part of a law suit? Yes _____ No _____

MEDICAL AND COUNSELING HISTORY

Have you ever consulted a therapist before? Yes _____ No _____ If so When? _____
How long? _____

Briefly state the reasons you sought counseling in the past. _____

Have you been or are you now taking any medications? Yes _____ No _____

If yes please list medications and for what problem. _____

Name and phone number of your medical doctor (if relevant):

Problem Checklist (past or current):

- Depression
- Anxiety
- Health problems
- Sleep problems
- Eating disorder
- Sexual problems
- Educational concerns
- Career choice concerns
- Job related problems
- Financial concerns
- Legal difficulties
- Caring for elders
- Death of loved one
- Caring for terminally ill or disabled loved one
- Suicidal thoughts
- Suicidal/self harming actions
- Traumatic experience
- Abuse ___ Physical (past present) ___ Sexual (past present) ___ Verbal (past present)
- Communication problems
- Infidelity ___ self ___ partner
- Jealousy
- Anger management
- Stress management
- Parent/child conflict (self)
- Parent/child conflict (other)
- Parental loss of control
- Sibling problems
- Blended family problems
- Alcohol/drug use (self)
- Alcohol/drug use (other)
- Compulsive behavior
- Domestic Violence
___ hitting ___ blocking exits/restraint ___
stalking
___ verbal/physical threats ___ shoving
other: _____

For those items checked, please expand on: