9185 E. Kenyon Ave. Ste 120
Denver, CO 80237
www.pcdcounseling.com
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AGENCY RECORD

Date_____

Name_____ Social Security #_____

Street Address_____ City _____

Zip Code _____

Birth Date_____ Sex_____

Cell Phone_____ Home Phone_____ WorkPhone_____

OK to leave msg on Cell? – Y/N on Home? – Y/N on Work? – Y/N

Email_____

Emergency Contact Person _____ Relationship? _____

Emergency Contact's Phone # _____

Occupation_____ Grade Completed_____

Spouse_____ Occupation _____

Date of Marriage/Divorce_____

Children (Names / Ages / Dates of Death)

_____

_____

_____

_____

Father_____Occupation_____

Mother_____Occupation_____

Siblings (Names / Ages / Dates of Death)

_____

_____

_____

Former Marriages (Dates)_____

Church_____ Pastor_____

Other important persons_____

Previous Counselors_____

Physician_____ Medications now used_____

_____

Significant Illnesses / Injuries / Physical Conditions / Hospitalizations / Etc in Your Life (Dates)

_____

_____

Recent Changes in Your Life_____

Statement of Problem_____

_____

_____

For Treatment Planning

Types of Counseling Desired: _____Individual _____Marital _____Famiy _____Group

What motivated you to seek therapy now? _____

_____

Please rate your level of distress in the relevant areas below. Use the following numbers to rate your distress:

0 – None 1 – Very Little 2 – Little 3 – Moderate 4 – Considerable 5 – Very Considerable 6 – Maximum

_____ Depression
_____ Suicidal thoughts
_____ Suicidal actions
_____ Anxiety
_____ Panic attacks
_____ Sleep problems
_____ Eating disorder
_____ Withdrawn behavior
_____ Health problems
_____ Job related problems
_____ Financial concerns
_____ Domestic violence
_____ Parent-child conflict (self)
_____ Parent-child conflict (other)
_____ Communication problems
_____ Other

_____ Alcohol/other drug use (self)
_____ Alcohol/other drug use(family)
_____ Marital/relationship problems
_____ Sexual problems
_____ Physical Abuse
_____ Legal difficulties
_____ Death of a loved one
_____ Compulsive gambling
_____ Self-esteem problems
_____ Career choice concerns
_____ Sexual abuse, actual
_____ Sexual abuse, threatened
_____ Brother/sister problems
_____ Blended family issues
_____ Parental loss of control
_____ Spiritual health

What goals do you want to accomplish in therapy?

_____

_____

_____

Referral

How did you find out about our counseling services?

_____

Who referred you? _____

Relationship _____

Address_____Phone_____