New Beginnings Psychological Resources
PO Box 440763 Aurora, Colorado 80044-0763
(303) 369-9152
Outside Metro Denver: (877) 819-0707

Protected Health Information (PHI)

TODAY'S DATE

Personal Information

Last Name	First Name	Middle Initial
Street Address		Apt. Number
City	State	Zip Code
Home Phone Number:	Cell Phone Number:	Pager:
Birth Date: ____ Month / Day / Year	Marital Status:	Social Security Number: — —

Employment Information

Name of Employer		Occupation
Street Address		
City	State	Zip Code
Work Phone Number Ext:	May we call you at work? ☐ Yes ☐ No	

OFFICE USE ONLY

☐ ACCOUNT # ____

FEE $ ____

INSURANCE? ____

Medical Information

Physician's Name	Phone Number

PLEASE LIST ALL MEDICATIONS YOU ARE NOW USING

Name of Medication	Presc / OTC	Dose	Times per day

Counseling Information

Do you feel that you are currently in crisis and could harm yourself or someone else? ☐ Yes ☐ No

WHAT IS YOUR REASON FOR SEEKING COUNSELING AT THIS TIME?

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Psychotherapy Information

CLIENT'S NAME	TODAY'S DATE

FAMILY INFORMATION

CURRENT MARRIAGE

Spouse's First Name:	Spouse's Last Name:	M.I.

Date of Marriage: ________ Month / Day / Year	Length of Engagement:
Spouse's Employer:	Work Phone:

Children by this relationship:

Name	Sex	Birth Date	Current Age	Living at home?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

PREVIOUS MARRIAGE / RELATIONSHIP

Partner's First Name:	Partner's Last Name:

Date of Marriage (or beginning of cohabitation): ________ Month / Day / Year	Your age at that time:

Length of Engagement:	Date of Divorce:	Date(s) Separated:

Children by this relationship:

Name	Sex	Birth Date	Current Age	Living at home?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Please ask therapist for additional marriage data pages if necessary to list other marriages / relationships.

FAMILY INFORMATION

FAMILY OF ORIGIN

Birth Father:	**Birth Mother:**
Father's Occupation:	**Mother's Occupation:**

Adoptive and / or Step Parents:

Brothers and / or Sisters:

Name	Sex	Birth Date	Current Age	Marital Status

PSYCHIATRIC HISTORY

Is there a history of addictions and / or mental illness in any of your blood relatives? If so, please describe:

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Have you seen a counselor / therapist previously? If so, when, how long, and for what reason?

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Have you been hospitalized for psychiatric reasons? If so, when, how long, and for what reason?

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MEDICAL HISTORY

Have you been hospitalized for medical reasons (surgery, etc.)? If so, when and for what reason?

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GENERAL INFORMATION

Have you experienced any of the following in your lifetime?

Physical abuse	☐ **Yes**	☐ **No**	**Dates**
Emotional abuse	☐ **Yes**	☐ **No**	**Dates**
Sexual abuse	☐ **Yes**	☐ **No**	**Dates**
Victim of violent crime	☐ **Yes**	☐ **No**	**Dates**
Concussion / Unconscious	☐ **Yes**	☐ **No**	**Dates**
Seizures / Dizziness	☐ **Yes**	☐ **No**	**Dates**
Suicide attempts	☐ **Yes**	☐ **No**	**Dates**
Legal problems	☐ **Yes**	☐ **No**	**Dates**

What is your current usage of the following?

	Average number of days used in last month	**Average amount used on each occasion**
Alcohol		
Non-prescription drugs		

Has your usage gone up or down in the last six months?

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Do you have any questions you would like me to answer at this time about my practice, your Protected Health Information (PHI), or any other matter?

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