

**Protected Health Information (PHI)**

**New Beginnings Psychological Resources**

PO Box 440763 ☞ Aurora, Colorado 80044-0763

(303) 369-9152

Outside Metro Denver: (877) 819-0707

<b>TODAY'S DATE</b>

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? <input type="checkbox"/> Yes <input type="checkbox"/> No

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
WHAT IS YOUR REASON FOR SEEKING COUNSELING AT THIS TIME?	
_____	
_____	
_____	
_____	

<p><b>FOR OFFICE USE ONLY</b></p> <p>ACCOUNT # _____</p> <p>FEE \$ _____</p>	<p>INSURANCE?</p> <p>DSM I    II    III    IV    V</p>
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**Psychotherapy**  
**Information**

<b>CLIENT'S NAME</b>	<b>TODAY'S DATE</b>
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**FAMILY INFORMATION**

<b>CURRENT MARRIAGE</b>		
<b>Spouse's First Name:</b>	<b>Spouse's Last Name:</b>	<b>M.I.</b>
<b>Date of Marriage:</b> _____ <small>Month / Day / Year</small>	<b>Length of Engagement:</b>	
<b>Spouse's Employer:</b>	<b>Work Phone:</b>	

<b>Children by this relationship:</b>				
<b>Name</b>	<b>Sex</b>	<b>Birth Date</b>	<b>Current Age</b>	<b>Living at home?</b>
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>PREVIOUS MARRIAGE / RELATIONSHIP</b>		
<b>Partner's First Name:</b>	<b>Partner's Last Name:</b>	
<b>Date of Marriage (or beginning of cohabitation):</b> _____ <small>Month / Day / Year</small>	<b>Your age at that time:</b>	
<b>Length of Engagement:</b>	<b>Date of Divorce:</b>	<b>Date(s) Separated:</b>

<b>Children by this relationship:</b>				
<b>Name</b>	<b>Sex</b>	<b>Birth Date</b>	<b>Current Age</b>	<b>Living at home?</b>
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

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

**FAMILY INFORMATION**

**FAMILY OF ORIGIN**

<b>Birth Father:</b>	<b>Birth Mother:</b>
<b>Father's Occupation:</b>	<b>Mother's Occupation:</b>

**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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dates
Emotional abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dates
Sexual abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dates
Victim of violent crime	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dates
Concussion / Unconscious	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dates
Seizures / Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dates
Suicide attempts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dates
Legal problems	<input type="checkbox"/> Yes	<input type="checkbox"/> 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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