Jennifer Kane, LSW, MSW, MA
Insight Counseling Center
190 E. 9th Avenue, Suite 290, Denver, CO 80203
303-517-2776

Date: _____

The following information is confidential unless otherwise mandated by law. Your cooperation in providing this material is not required but will be extremely helpful in beginning your therapy process.

Name: _____ Employer: _____

Home Address: _____ Occupation: _____

City_____ Zip_____ Work Address:_____

Work Phone: _____ OK to leave message?** ___yes ___no
Home Phone: _____ OK to leave message?** ___yes ___no
Cell/Alt. Phone #: _____ OK to leave message?** ___yes ___no

Birth date: _____ Partner's Name (if being seen as a couple) _____

Email Address:_____

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

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 Jennifer Kane to contact you by email you are consenting to receive electronic communications and understand the risks involved.

IN CASE OF AN EMERGENCY
I authorize Jennifer Kane/Insight Counseling to contact the following person(s) in case of emergency:

Name_____ Relationship_____ Phone (___)_____

Address: Street: _____ City/State:_____ Zip Code: _____

PAYMENT and CANCELLATION POLICY

Payment in full is required at the end of each session. Cancellations later than 24 hours before a scheduled session will be billed at 50% of the agreed rate. Because I do not accept insurance, you are receiving a discounted rate of _____ per session. You may pay in cash, check, or credit card on file after any session. If you are seeing me as part of your employer's EAP, please provide the employee or authorization number before our first session and at the start of any subsequent number of sessions.

Client Signature _____ Date _____

Authorization or employee number if indicated _____

PERSONAL INFORMATION

Name:_____

Referred by: _____

Previous Counseling/Treatment:

(Who) _____ (Where) _____ (When) _____

(Results)_____

(Who) _____ (Where) _____ (When) _____

(Results)_____

Nature of Current Problems: _____

_____

_____

_____

Others Living in the Home:

Name _____ DOB ___/___/___ School/Employer: _____

Name _____ DOB ___/___/___ School/Employer: _____

Name _____ DOB ___/___/___ School/Employer: _____

Name _____ DOB ___/___/___ School/Employer: _____

MEDICAL INFORMATION

Primary Care Physician: _____ Date of Last Visit: _____

Address: _____ Medical Issues: _____

Physician's Phone: _____ _____

Allergies: _____ Current Medications: *(Include dosage and length of usage)*_____

Adverse Reaction to Medications _____

CURRENT CONCERNS AND RESOURCES

CONCERNS & GOALS: What brings you to counseling / therapy? What do you hope to accomplish? _____

_____

_____

_____

Strengths/Support System/Community Resources: _____

_____

_____

Is there anything else about your health, mental health, or current situation that you would like me to know in order to enhance our work together? _____

_____

HEALTH: Check and describe the following, with dates, as they apply to you:

_____ Current / chronic medical conditions / infectious diseases _____

_____ Recent weight changes: Lost / gained _____ lbs. in _____ weeks/months? Intentional? Y N

_____ Serious illnesses / injuries / traumas _____

_____ Surgeries / hospitalizations (medical / psychiatric) _____

Rate your current distress level for each symptom / concern that applies to you**, using the scale below**:

0 1 2 3 4 5 6

None Very little Mild Moderate Considerable Severe Maximum

_____ Depression
_____ Hopelessness
_____ Anxiety
_____ Panic attacks
_____ Withdrawn behavior
_____ Social Anxiety
_____ Loss of / increased appetite
_____ Mood swings
_____ Anger / rage
_____ Fearfulness
_____ Guilt
_____ Suicidal thoughts
_____ Suicidal actions
_____ Homicidal thoughts / actions
_____ Obsessive thoughts _____
_____ Compulsive behaviors _____
_____ Paranoid thoughts / behaviors
_____ Hallucinations (audio / visual)
_____ Memory problems (short term / long term)
_____ Concentration / lack of focus
_____ Perfectionism
_____ Health concerns
_____ Hormonal / endocrine imbalances
_____ Self esteem concerns
_____ Grief / losses (identify) _____
_____ Loss of meaning in life
_____ Alcohol / other drug abuse (self)

_____ Alcohol / other drug abuse (who?) _____
_____ Nicotine addiction – amt. _____
_____ Caffeine addiction – amt. _____
_____ Eating disorders
_____ Compulsive gambling
_____ Pornography
_____ Sexual addiction
_____ Computer / internet addiction
_____ Other addictions (identify) _____
_____ Communication problems
_____ Sexual problems
_____ Marital / relationship conflicts
_____ Domestic violence
_____ Blended family problems
_____ Conflict with parents
_____ Conflict with siblings
_____ Conflict with children
_____ School / work conflicts
_____ Emotional abuse (past / current)
_____ Physical abuse (past / current)
_____ Sleep problems (describe)
_____
_____ Other (describe)
_____
_____ Sexual abuse (past / current)
_____ Legal problems
_____ Financial problems
_____ Job / employment problems

Substance Abuse Information

List all of the prescription and over-the-counter drugs you are taking

_____

_____

_____

	FIRST USE	# DAYS PER WEEK	LAST USED
Beer			
Liquor			
Wine			
Marijuana			
Cocaine/crack			
Methamphetamine			
Heroin			
Prescription Pain killers			
PCP, LSD			
Ecstasy			
Other			

	Circle	
Have you ever felt like you should cut down on your drug or alcohol use?	yes	no
Has a friend or relative expressed concerns about your use?	yes	no
Have you ever felt guilty about your drinking or drug use?	yes	no
Have you ever had to take a drink or use a drug the next day to steady your nerves?	yes	no
Are you a recovering alcoholic or a recovering drug addict?	yes	no
Is there a history of problems with drug or alcohol use in your family?	yes	no

To be completed by adolescents (12 yrs to 17 yrs)

Have you ever used alcohol or drugs before or during school?	yes	no
Have you ever missed school (or been truant) because of use or just to use?	yes	no
Have you ever avoided non-users?	yes	no

How often do you get drunk/high? _____

About how often do you use more than one drug when you get high? _____

Is there a history of problems with drug or alcohol use in your family? yes no

_____ _____ ____/____/____

Client Signature Parent/Legal Guardian Signature Date of Signature