



# CAPITOL PEAK COUNSELING, PLLC

Jennifer Worcester, MA, LPC

19563 E Mainstreet Suite 206-E Parker CO 80138

303.475.2323 [www.capitolpeakcounseling.com](http://www.capitolpeakcounseling.com) [jennifer@capitolpeakcounseling.com](mailto:jennifer@capitolpeakcounseling.com)

## Client Information:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_ Can I contact you at this email address? Yes No

Home Phone: \_\_\_\_\_ Can messages be left at this number? Yes No

Cell Phone: \_\_\_\_\_ Can messages be left at this number? Yes No

Date of Birth: \_\_\_\_\_ Last 4 digits of your social security number: \_\_\_\_\_

| Children's Names | M/F | Age | Mother/Father's Name | Do they live with you? |
|------------------|-----|-----|----------------------|------------------------|
| _____            |     |     |                      |                        |
| _____            |     |     |                      |                        |
| _____            |     |     |                      |                        |

Relationship Status (Single, Married, Life Partner, Dating, or Other) : \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship of Emergency Contact: \_\_\_\_\_

Do you currently have any ongoing court cases? If yes, please describe: \_\_\_\_\_

## Financial Responsibility:

Who is financially responsible for services? \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Policy Holder's Social Security # : \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

**Family History:**

|          | Living? | Age or Age at Death | Present Health/Cause of Death |
|----------|---------|---------------------|-------------------------------|
| Father   | _____   | _____               | _____                         |
| Mother   | _____   | _____               | _____                         |
| Siblings | _____   | _____               | _____                         |
|          | _____   | _____               | _____                         |
|          | _____   | _____               | _____                         |

Do you have any family history of mental illness? (Bipolar, Schizophrenia, Depression, etc.) Yes No

Do you have any family history of learning difficulties or behavior problems? Yes No

If you answered yes to the above questions, please provide additional information below:

\_\_\_\_\_  
\_\_\_\_\_

**Medical /Mental Health History:**

Family Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Date of last physical: \_\_\_\_\_ Date of last hospitalization: \_\_\_\_\_

Please list any previous counseling or other relevant treatment (counseling, hospitalization, etc.):

| Provider's Name: | Date Began: | Date Ended: |
|------------------|-------------|-------------|
|                  |             |             |
|                  |             |             |
|                  |             |             |
|                  |             |             |

Please list current and previous medications:

| Medication: | Dosage: | Date Began: | Date Ended: | Prescribing Physician: |
|-------------|---------|-------------|-------------|------------------------|
|             |         |             |             |                        |
|             |         |             |             |                        |
|             |         |             |             |                        |
|             |         |             |             |                        |

|   |     |    |
|---|-----|----|
| Have you ever been given a mental health diagnosis?                             | Yes | No |
| Have you ever been hospitalized for mental health reasons?                      | Yes | No |
| Have you attempted suicide in the past?   | Yes | No |
| Do you have thoughts of harming yourself or someone else at this time?          | Yes | No |
| Have you been diagnosed with any mental illness?                                | Yes | No |
| Have you ever received treatment for substance abuse?                           | Yes | No |
| Do you use tobacco?   | Yes | No |
| Do you use alcohol?   | Yes | No |
| Do you use any other substances such as marijuana, cocaine, amphetamines, etc.? | Yes | No |

Please circle any of the following symptoms/conditions that are present now or in the past:

|                  |                                       |                 |                        |
|------------------|---------------------------------------|-----------------|------------------------|
| Headaches        | Irritability                          | Diabetes        | Stress                 |
| Dizziness        | See or Hear Things that are not There | Abuse           | Anxiety                |
| Head Injury      | Weight Gain or Loss                   | Fertility       | Marital                |
| Thyroid Problems | Thoughts of Self Harm                 | Sexual Problems | Feeling Out of Control |
| Fatigue          | Depression                            | Anemia          | Difficulty Sleeping    |
| Heart Trouble    |                                       | Allergies       |                        |
|                  |                                       | Legal Problems  |                        |

Please list/describe any other medical disease/condition that you may have or experienced that is not mentioned above:

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Do you have any history of emotional, physical, or sexual abuse? If so, please describe below:

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**Other:**

What are your reasons for seeking counseling/parenting services at this time?

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Is there anything else you would like to share that was not asked above?

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How were you referred to Capitol Peak Counseling or Jennifer Worcester?

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