



# CAPITOL PEAK COUNSELING, PLLC

Jennifer Worcester, MA, LPC

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## Clients Information:

Family Members Names:	Date of Birth:	Living in the Home: Yes/No	Will they be attending counseling?: Yes/No	Employer or School Attending:

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

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

## 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 Members:	Physician:	Date of last physical:	Any Medical conditions or concerns (thyroid, allergies, hospitalizations ,disease, etc.):	Describe and current or previous substance abuse including alcohol and tobacco.

**Medical /Mental Health History:** (Provide information for family members attending counseling.)

Please list any medications (prescription or nonprescription) that family members are currently taking:

Family Member:	Medication:	Dosage:	Date Began:	Date Ended:	Prescribing Physician:

Please provide information regarding previous treatments (counseling, occupational therapy

Family Member:	Provider	Dates of Service:	Purpose:

Does any family member have a history of physical/sexual/emotional abuse?      Yes    No

Has any family member been given a mental health diagnosis?                      Yes    No

Has any family member had a suicide attempt?                                              Yes    No

Please circle any of the following symptoms/conditions that family members are experiencing and indicate which family member:

Headaches  
\_\_\_\_\_

Diabetes  
\_\_\_\_\_

School Problems  
\_\_\_\_\_

Dizziness  
\_\_\_\_\_

Abuse  
\_\_\_\_\_

Difficulties Making Friends  
\_\_\_\_\_

Head Injury  
\_\_\_\_\_

Sexual Behavior Problems  
\_\_\_\_\_

Repetitive Behaviors  
\_\_\_\_\_

Fatigue  
\_\_\_\_\_

Anemia  
\_\_\_\_\_

Difficulty with Change  
\_\_\_\_\_

Heart Trouble  
\_\_\_\_\_

Allergies  
\_\_\_\_\_

Defiance  
\_\_\_\_\_

Irritability  
\_\_\_\_\_

Legal Problems  
\_\_\_\_\_

Hyperactivity  
\_\_\_\_\_

See or Hear Things that are not  
There  
\_\_\_\_\_

Stress  
\_\_\_\_\_

Difficulty with Attention  
\_\_\_\_\_

Weight Gain or Loss  
\_\_\_\_\_

Anxiety  
\_\_\_\_\_

Poor Boundaries  
\_\_\_\_\_

Feeling Out of Control  
\_\_\_\_\_

Restricted Interest  
\_\_\_\_\_

Thoughts of Self Harm  
\_\_\_\_\_

Difficulty Sleeping  
\_\_\_\_\_

Difficulty  
\_\_\_\_\_

Depression  
\_\_\_\_\_

Thyroid Problems  
\_\_\_\_\_

Learning  
\_\_\_\_\_

Rituals  
\_\_\_\_\_

Please list/describe any other medical disease / condition of family members that is not listed above:

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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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This form is being completed by: \_\_\_\_\_