Heather Gowin, MA, LPC
Licensed Professional Counselor 720-837-7962
357 McCaslin Blvd.
Louisville, CO 80027

# INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):
_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Please list any children/age: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) Cell/Other Phone: ( )

May we leave a message at either of these numbers? □ Yes □ No

E-mail: _____
May we email you? □ Yes □ No
***Please note: Email correspondence is not considered to be a confidential medium of communication.***

Insurance_____

Insured Name_____ Insured Date of Birth_____

ID number_____ Insured Employer_____

Group Number_____ Insurance Phone Number_____

Referred by (if any): _____

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Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes

Previous therapist/practitioner: _____

Are you currently taking any prescription medication?
□ Yes □ No

Please list: _____
Have you ever been prescribed psychiatric medication?
□ Yes □ No

Please list and provide dates: _____
_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in? _____

4. Please list any difficulties you experience with your appetite or eating patterns:

_____

5. Are you currently experiencing overwhelming sadness, grief, or depression?
□ No
□ Yes

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If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?
□ No
□ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
□ No
□ Yes

If yes, please describe: _____

8. Do you drink alcohol more than once a week?
□ No
□ Yes

9. How often do you engage recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship?
□ No
□ Yes

If yes, for how long? _____

FAMILY MENTAL HEALTH HISTORY:
In the section below, identify if there is a family history of any of the following. If yes, check the box and then please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

| | | |
|---|---|---|
| Alcohol/Substance Abuse | □ | _____ |
| Anxiety | □ | _____ |
| Depression | □ | _____ |
| Domestic Violence | □ | _____ |
| Eating Disorders | □ | _____ |
| Obesity | □ | _____ |
| Obsessive Compulsive Behavior | □ | _____ |
| Schizophrenia | □ | _____ |
| Bipolar Disorder | □ | _____ |
| Suicide Attempts | □ | _____ |

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ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes
If yes, what is your current employment situation?
_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:
_____

3. What do you consider to be some of your strengths?
_____
_____
_____
_____

4. What do you consider to be some of your weaknesses?
_____
_____
_____
_____