

Summit Counseling Associates, Inc

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Client Information Form

To enable us to spend as much time discussing your concern during the first session, please complete this form as fully as possible. If you have any questions about a particular section, please leave that section blank.

Today's Date:

How did you hear about Summit Counseling Associates?

Husband / Male

| | | |
|--------------------|------|--------|
| Name (Last, First) | | |
| Street Address: | | |
| City: | Zip: | |
| Telephone: | Cell | |
| Age: | DOB | Email: |

Wife / Female

| | | |
|---------------------|-------|--------|
| Name (Last, First): | | |
| Street Address: | | |
| City | Zip | |
| Telephone | Cell: | |
| Age: | DOB | Email: |

Marital Status

| Husband / Male | Wife / Female |
|--|--|
| (Check one) | (Check one) |
| <input type="checkbox"/> Single, never married | <input type="checkbox"/> Single, never married |
| <input type="checkbox"/> Engaged | <input type="checkbox"/> Engaged |
| <input type="checkbox"/> Married, first marriage | <input type="checkbox"/> Married, first marriage |
| <input type="checkbox"/> Married, second marriage | <input type="checkbox"/> Married, second marriage |
| <input type="checkbox"/> Married, third or more marriage | <input type="checkbox"/> Married, third or more marriage |
| <input type="checkbox"/> Separated | <input type="checkbox"/> Separated |
| <input type="checkbox"/> Divorced | <input type="checkbox"/> Divorced |
| <input type="checkbox"/> Widowed | <input type="checkbox"/> Widowed |

Emergency Contact Information

I give my permission to Dr. Craig Loving to contact the above person(s) in case of emergency. I authorize this person to answer questions about my physical and mental health. I understand that I may revoke this authorization at any time by **giving Dr. Loving written notice.**

| | |
|--------------------|---------------------|
| Signature | Date |
| Name (Last, First) | Relationship to you |
| Street Address | |
| City | Zip |
| Telephone | Cell |

If client is minor, name of adult seeking treatment

| | |
|---|------|
| Name (Last, First) | |
| Street Address | |
| City | Zip |
| Telephone | Cell |
| Relationship to minor: <input type="checkbox"/> Parent <input type="checkbox"/> Step-Parent <input type="checkbox"/> Legal Guardian | |
| I have legal right to seek treatment for this minor: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Signature | Date |

Primary Care Physician

| | |
|--|-----------------------------|
| Name | |
| Address | |
| City | Zip |
| Telephone | Date of last visit (approx) |
| (OPTIONAL) I authorize Dr. Craig Loving to contact my PCP to discuss relevant information concerning medical condition (e.g., diagnosis, prescribed medications, treatment history, etc.). I understand that I may revoke this authorization at any time by giving Dr. Loving written notice. | |

Prescription Medications

| Name | Dosage | x per day |
|------|--------|-----------|
| | | |
| | | |
| | | |
| | | |
| | | |

Over-the-counter medicine

| Name | Dosage | x per day |
|------|--------|-----------|
| | | |
| | | |
| | | |
| | | |
| | | |

Vitamins / Supplements

| Name | Dosage | x per day |
|------|--------|-----------|
| | | |
| | | |
| | | |
| | | |
| | | |

How would you describe your current health?

- Excellent
 Good
 Fair
 Poor

Current Drug / Alcohol Use

| What | How Much |
|------|----------|
| | |
| | |
| | |
| | |

Briefly describe the issue you are seeking help for

PROBLEM INTENSITY: How would you **rate the intensity** of the problem or concern that brought you in? (Check the appropriate number):

- 1
 2
 3
 4
 5
 6
 Not Intense Moderately Intense Extremely Intense

How long has this issue been a problem for you?

Briefly describe what you have done to try to resolve this issue

Name(s) of other counselor(s) you have seen about this issue.

(OPTIONAL) I authorize Dr. Craig Loving to contact my previous counselors to discuss relevant information concerning my treatment with them. I understand that I may revoke this authorization at any time by **giving Dr. Loving written notice.**

Signature

Date

Please choose the phrase that best describes your motivation for today's visit:

- 1. I don't have a problem; someone else thinks I do.
- 2. I do have a problem; I do want to change, but at the same time I don't want to change.
- 3. I am getting ready to change and am about to make the commitment.
- 4. I have already begun taking action to resolve this problem.
- 5. I have achieved my goal and focused on preventing relapse.
- 6. I have relapsed and I am seeking to regain control.

FAMILY BACKGROUND

1. Please list the members of your current family, including ages and occupations (e.g. father, 42, lawyer; stepmother, 40, teacher; brother 16, student; etc.)

2. Please check any past, present, or impending special problems in your family:

- | | |
|--|---|
| <input type="checkbox"/> deaths | <input type="checkbox"/> divorce |
| <input type="checkbox"/> frequent relocations | <input type="checkbox"/> debilitating injuries/disabilities |
| <input type="checkbox"/> serious illness | <input type="checkbox"/> psychiatric disorder |
| <input type="checkbox"/> alcohol/drug abuse | <input type="checkbox"/> physical/sexual abuse |
| <input type="checkbox"/> financial crisis/unemployment | <input type="checkbox"/> legal problems |
| <input type="checkbox"/> attempted/completed suicide | <input type="checkbox"/> eating disorders |
| <input type="checkbox"/> other | |

Please specify family member(s), which special problem, and approximate year of occurrence (e.g. mother-serious illness, 1998 etc.)

3. Have you personally experienced significant **family abuse**?

- None Unsure Emotional Physical Sexual

4. Have you personally experienced **legal problems**? No Yes

5. Did you experience **learning problems** in elementary or high school? (Check one):

- None Little Some Substantial Lots Constant struggle

6. In general, how **happy or adjusted** were you growing up? (Circle one):

- Poor Unsatisfactory About average Substantial Completely

7. How much is your immediate family a source of **emotional support** for you? (Circle one):

- None Little Somewhat Substantial Very Strong

8. How much **conflict in values** do you currently experience with your parents? (Circle one):

- Very little or none Some Moderate Strong Extreme

9. Who in your family do you currently **feel closest** to? _____

Most **distant** from? _____ In most **conflict** with? _____

HEALTH AND SOCIAL ISSUES

1. How is your **physical health** at present?

- Poor Unsatisfactory Satisfactory Good Very good

2. Please list any **persistent physical symptoms** or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

3. Are you presently taking any **prescribed medication**? No Yes

Please indicate:

4. Are you having any problems with your **sleep habits**? No Yes

(If yes, check where applicable):

- Sleeping too little Sleeping too much Poor quality sleep Disturbing dreams Other

5. How many times per week do you **exercise**? _____ For about how long each time? _____

6. Are you having any difficulty with **appetite or eating habits**? No Yes

(If yes, check where applicable): Eating less Eating more Binging Restricting

Significant weight change (last 2 months)

7. Do you regularly use **alcohol**? Yes No

In a typical month, how often do you have 4 or more drinks in a 24 hour period? _____

Do you consider your alcohol consumption a problem? Yes No Unsure

8. How often do you engage **recreational drug use**?

- Daily Weekly Monthly Rarely Never

Do you consider this drug use a problem? Yes No Unsure

9. Do you have any problems or worries about **sexual functioning**? No Yes
(If yes, check where applicable): Lack of desire Performance Problem Sexual Impulsiveness
 Difficulties maintaining arousal Worried about sexually transmitted disease Other
10. Have you ever experienced **sexual assault, unwanted sex or uncomfortable touching**?
 Frequently A few times Once Never Unsure
11. Have you had **suicidal thoughts** recently? Frequently Sometimes Rarely Never
Have you had them in the past? Frequently Sometimes Rarely Never
12. Have you had a family member or close friend who committed suicide?
 Yes No
13. Have you ever intentionally **inflicted any harm upon yourself**? Yes No Unsure
14. In the past, how would you rate the quality of your **peer relationships**?
 Very Poor Unsatisfactory About Average Good Excellent
15. Approximately how many **significant intimate relationships** (e.g. lasting 6 months or more) have you been involved in? _____ Are you in one now? Yes No I think so
16. Besides family members, approximately how many people can you really count on right now for **friendship or emotional support**? _____
17. Are you generally about changing this issue? (check one)
 Optimistic Undecided Pessimistic
18. How does this issue affect your family relationships? (check one)
 Negative Neutral Not a problem yet
19. How does this issue affect your work relationships? (check one)
 Negative Neutral Not a problem yet
20. How does this issue affect your social relationships (friends, associates, church, etc)? (check one)
 Negative Neutral Not a problem yet
21. How does this issue affect your relationship with God? (check one)
 Negative Neutral Not a problem yet
22. How does this issue affect your attitude toward yourself? (check one)
 Negative Neutral Not a problem yet