Laura McCarthy, PhD, LMFT
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Lakewood, CO 80235
720-384-4696

Client Name:_____ Date of Birth:_____ Gender: M F

Nick name, or prefer to be called:_____

Street Address:_____ City/State/Zip:_____

(Please circle or star your preferred phone number)

Home Phone:_____ Messages okay? Y○ or N○

Work Phone:_____ Messages okay? Y○ or N○

Cell/Other Phone:_____ Messages okay? Y○ or N○ Text okay? Y○ or N○

Email address:_____ Ok to send email? Y○ or N○

Emergency Contact Name:_____ Relationship:_____

Emergency Contact Phone Numbers:_____

Marital Status: Never Married __ Married (# of yrs _____) __ Committed Relationship Separated Divorced Widowed

Occupation:_____

Please check any current symptoms you are experiencing:

____Depression/Sadness	____Isolation/Withdrawal	Suicidal Thoughts
____Aggression/Violence	____Homicidal Thoughts	Self-Harm/Injury, Cutting, Etc.
____Appetite Problems	____Impulse Control Difficulty	____Anxiety, Panic, Worry, or Phobia
____Sleep Disturbance	Difficulty Expressing Feelings	Obsessions and/or Compulsions
Anger/Irritability	Victim of Abuse	Low Self-Esteem/Confidence
____Domestic Violence	____Perpetrator of Abuse	____Problems Thinking/Concentrating
____Relationship Conflicts	____Addictive Behavior	____Pronounced Mood Swings
Workplace Stress	____Alcohol/Substance Abuse	Stress/Feeling Overwhelmed
____Communication/Trust Problems	____Grief/Loss	____Legal/Financial Problems
____Chronic Medical Problems	____Parenting Issues	Religious/Spiritual Issues
Binging/Purging/Anorexia	____Sexual/Intimacy Issues	Questioning of Sexual-Orientation/Gender

Indicate any current medications related to mental health/behavioral health (e.g., anti-depressants, anti-anxiety, sleep medications, Antabuse, etc.):_____

Name and phone number of prescribing professional:_____

If not on medication, is a referral for a medication evaluation needed? Yes ○ No ○ Maybe ○

Please list any current physical health concerns:_____

_____

Please list past and present tobacco, alcohol, and drug use:_____

_____

Who referred you to see me?_____ (e.g., friend, name of doctor, name of website, etc.)

At times, I write a newsletter with articles and tips that may provide additional help. May I email you my newsletter? (Your confidentiality will be protected, and your information will never be given to a third party.) Y○ or N○

What concern brings you in? What goals do you hope to achieve through counseling? _____

_____

_____

_____

Have you participated in therapy before? If so, what was helpful and/or unhelpful about the experience? If not, what are your hopes and/or reservations about therapy? _____

_____

_____

_____

How do you feel our therapy together can be most helpful? Do you have thoughts or preferences about how you would like therapy to proceed? _____

_____

_____

_____

Thank you for taking the time to complete this information!