Pathwise Counseling and Skills Center, PLLC
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720-355-4082

Initial Client Contact Form

Name of Client_____ Date_____
Name of Person Completing Form if different from above _____
Relationship to Client _____
Phone # if different from Client's primary contact _____

Client Information
Date of Birth _____ Gender _____ Race/Ethnicity _____
Primary Spoken Language _____ Other Spoken Language(s) _____
Email _____OK to contact via email_____ YES or _____NO
Home Phone # _____ OK to leave voicemail at home phone #_____ YES or _____NO
Cell Phone # _____ OK to leave voicemail at cell phone # _____ YES or _____NO
Work Phone # _____ OK to leave voicemail at work phone # _____ YES or _____NO
Preferred Contact (Must include at least one phone #) _____ HOME _____ CELL _____ WORK _____ EMAIL
Address _____
Religious Preference: _____ Birth Place: _____
Annual Income:
___ Less than $10,000 ___ $10,000-14,999 ___ $15,000-24,999 ___ $25,000-49,999 ___ $50,000-99,999
___ $100,000-149,000 ___ $150,000-199,999 ___ More than $200,000 ___ Unknown ___ Decline Answer

Current/Previous Therapist _____ Therapist's Phone # _____
Current/Previous Psychiatrist _____ Psychiatrist's Phone #_____
Primary Care Physician _____ PCP's Phone # _____
Emergency Contact _____ Phone # _____
Relationship to You _____
Do you give Pathwise Counseling consent to contact this person in the event of an emergency: _____YES _____NO

Intended method of payment: Circle - Insurance Self-Pay (Cash, check, credit card) EAP DHS/Probation Funded
Please note that Pathwise Counseling accepts Medicaid and is an OUT-OF-NETWORK provider for other insurance companies.

What are the problem(s) for which you are seeking mental health help?
1. _____
2. _____
3. _____

What do you want to accomplish in mental health treatment?
_____
_____

How did you learn about Pathwise Counseling: ___Website ___Psychology Today ___Friend/Family ___Other

Client Signature _____ Date _____