TurningPoint Counseling
19563 E Mainstreet, Suite 206G
Parker, CO 80138
Lisa McSeveney, LMFT **Telephone: 760 608-3746**

CLIENT INFORMATION

Please take the time to fill out this confidential client information form prior to your first session. This information will help me get to know you and facilitate the beginning of your therapy. Thank you!

Client_____ Date of Birth:___/___/___ *Current Age_____

Address: _____ City:_____ State: ____ Zip: _____

Cell Phone: (____) _____ Home Phone: (____) _____ Work Phone (____)_____

Sex: Male Female Subscriber S.S.# (if using insurance): _____-_____-_____

Employer/School Job Title/Grade

Marital Status: Married Single Divorced Widowed Partner's Name_____

Emergency Contact:_____ Telephone:(____) _____

Referred by: _____

Sign here for permission to send thanks if a professional referred you: _____

Relevant medical conditions (history, current condition, changes in condition):

_____

_____

Medications (dosage, dates of initial prescriptions, name of prescribing professional):

_____

_____

Allergies/adverse reactions to treatment: :_____

Primary Care Physician Name: _____ Telephone _____

Address:_____

Date of last medical/physical exam_____

Reason for seeking therapy_____

_____

TreatmentGoals_____

_____

Past therapy or psychiatric treatment_____

What, if anything, was helpful? :_____

_____

Psychiatric hospitalizations (Dates and Locations):_____

Family History of therapy, psychological, or psychiatric treatment: _____

_____

Do you drink coffee? Y or N (#_____cups/daily) Do you smoke Cigarettes? Y or N (#_____per day)

Alcohol? Y or N (#_____drinks weekly) Date last drank_____ Family History of Alcoholism? Y or N

Recreational Drug Use (Marijuana, Cocaine, Methamphetamine, etc.)? Y or N

Police / Probation involvement (past or present) Y or N Date_____ Please explain _____

_____

Family Structure (who lives in your household? Please provide names, ages and relationship to each)

_____

_____

Please circle if you have experienced any of the following (past or present):

Mood Changes	Worry/Fear	Panic Attacks	Poor Concentration
Tearfulness	Fatigue	Feeling Hopeless/Helpless	Sleep Problems
Body Image Problems	Sexual Problems	Losses	Phobias
Learning Problems	Spending Sprees	Outbursts of Anger	Lying
Seizures	Head Injury	Gambling Problems	Computer Addiction
Sexual Abuse	Domestic Violence	Traumas	Physical Abuse
Suicide Attempts	Suicidal Ideation	Auditory Hallucinations	Visual Hallucinations

Any other information you believe may be significant_____

_____