**Renee Storm,**
**LPC, CAC III, CSAT, EMDR**
14960 Woodcarver Rd. Ste. #202
Colorado Springs, CO 80921
720-281-0495

# COUNSELING INTAKE FORM - ADULT

Trauma Recovery Counseling Services and your therapist ask that you complete this form to the best of your ability. While you are not required to supply the information requested, know that the more information you provide, the better TRCS, LLC. is able to meet your specific needs. This information may be considered confidential; however, certain otherwise confidential information may be shared as required by law. The completed intake form will be kept in the client file and maintained under the same confidentiality protections as the therapeutic record, as detailed in the TRCS, LLC. Disclosure Statement and HIPAA Form.

## Contact Information

_____ _____
Client Name Today's Date

_____ _____ _____ _____
Street Address, City, State, Zip

Mobile Phone: _____ OK to leave a message? Y or N

Home Phone: _____ OK to leave a message? Y or N

Work Phone: _____ OK to leave a message? Y or N

Email: _____ OK to email you? Y or N

See the Trauma Recover Counseling Services, LLC. HIPAA and Notice of Privacy Policies and Consent for Communication by Non-Secure Transmission form before agreeing to receive communication via electronic means.

_____
Emergency Point of Contact (POC)

_____
Relationship to Client

_____
Emergency POC Phone

OK to leave a message? Y or N

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**Demographics**

_____ _____ Gender: ▫ Male ▫ Female ▫ Other: _____
Client Date of Birth Current Age

Relationship Status (circle all that apply):

Single Married Cohabitating Divorced Separated

Other: _____

Ethnicity: _____

Employment Status: FT PT Student Unemployed Not Desiring Outside Employment

Employer: _____

Health Insurer: _____ Is your primary insurance Medicaid? Y or N

Household Annual Income: _____

_____ _____
Physician Name Phone

_____ _____
Psychiatrist/Prescriber Name Phone

_____ _____
Previous Counselor Name Phone

Please note that in accordance with applicable HIPAA and Colorado regulations, we will not contact your physician, psychiatrist, or counselor without your knowledge and consent.

How did you hear about Trauma Recovery Counseling Services, LLC.?

_____

_____

_____

_____

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**Current Concerns**

What led you to seek counseling?

_____

_____

_____

_____

In the past, what has been helpful for you in dealing with this issue?

_____

_____

_____

_____

Among your friends and family, who provides support (physical, emotional, spiritual, financial, etc.)?

_____

_____

_____

_____

_____

What part does faith, religion, or spirituality play in your life?

_____

_____

_____

_____

Do you attend a place of worship? □ YES □ NO If so, where? _____

_____

_____

_____

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**Danger to Self or Others**

Have you ever had thoughts of harming yourself or others?

□ YES □ NO If yes, please explain:

_____

_____

Have you ever seriously considered suicide or attempted suicide?

□ YES □ NO If yes, explain:

_____

_____

Do you have the intent and means to commit suicide now?

□ YES □ NO If yes, explain:

_____

_____

Do you have the intent and means to harm or kill someone other than yourself right now?

□ YES □ NO If yes, explain: _____

_____

**Medical and Mental Health History**

Are you experiencing any physical symptoms such as over/under eating, sleeping problems, chest pain, anxiety, depression, shortness of breath, etc.? □ YES □ NO If yes, please explain:

_____

_____

_____

_____

_____

_____

_____

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Are there any significant past or present health or medical issues that we should be aware of?
YES □ NO If yes, please explain:

_____

_____

_____

Are there any significant past or present mental health issues that we should be aware of?
□ YES □ NO If yes, please explain:

_____

_____

_____

_____

Are there any significant past or present developmental issues that we should be aware of? □
YES □ NO If yes, please explain:

_____

_____

_____

Have you ever experienced abuse (emotional, physical, and/or sexual)?
□ YES □ NO If yes, please describe, to include dates and relationship of the abuser:

_____

_____

_____

Have you ever experienced other types of trauma, to include head injury/concussion?
□ YES □ NO If yes, please describe:

_____

_____

_____

Have you ever experienced flashbacks concerning trauma?
□ YES □ NO If yes, please describe:

_____

_____

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**Medication, Substance Use, and Addiction**

Please list all medications you are now taking and/or have taken in the past 3 months:

| Medication: | Dosage: | Prescriber: |
|---|---|---|
| How long? | Helpful? | Reason/Comments: |

Please indicate whether you use (or have used in the past) the following substances:

**Tobacco**: □YES □NO

Starting age/extent:

_____

_____

**Marijuana**: Drugs: □YES □NO

Starting age/extent:

_____

_____

**Alcohol**: □YES □NO

Drink(s) of choice:

_____

Drinks per week:

_____

Starting age/extent:

_____

_____

**Other**: □YES □NO

Drug(s) of choice:

_____

Substance(s) of choice:

_____

Starting age/extent:

_____

_____

Do you have other addictions, such as food, gambling, shopping, pornography, etc.?

□ YES □ NO If yes, please explain:

_____

_____

_____

_____

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**Family of Origin**

Describe your immediate family (e.g. parents, siblings, ages, etc.):

_____

_____

_____

_____

Does your family, whether biological or adopted, struggle with mental illness, chemical dependency, suicidality, etc.? □ YES □ NO If yes, please explain:

_____

_____

_____

_____

**Relationship Status**
Describe your relationship with your current partner. Please include how long you have been together and/or married:

_____

_____

_____

What are the strengths of your relationship? _

_____

_____

_____

What are the weaknesses of your relationship?

_____

_____

_____

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What do you like most about your partner?

_____

_____

_____

What do you dislike about your partner or have a hard time tolerating?

_____

_____

_____

Describe any domestic violence or other abusive behavior in your relationship:

_____

_____

_____

**Children**
Please list and describe your children, living and deceased, indicating whether biological, step, adopted, foster, etc.

| *Name:* | Age: | Gender: |
|---|---|---|
| _____ | _____ | _____ |
| With you? | Status/Comments: | |
| _____ | _____ | |
| *Name*: | Age: | Gender: |
| _____ | _____ | _____ |
| With you? | Status/Comments: | |
| _____ | _____ | |
| *Name*: | Age: | Gender: |
| _____ | _____ | _____ |
| With you? | Status/Comments: | |
| _____ | _____ | |

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**Completion**

I came here today _____

My relationship is _____

I am really happy when _____

I feel mad when _____

I wish _____

Growing up in my family _____

If I could change one thing _____

Six months from now _____

**Additional Questions**

If you have had therapy before, what worked best for you? What would you have changed?
_____

_____

_____

How will you know that therapy has been a success?
_____

_____

_____

What do you want life to look like upon the completion of therapy?
_____

_____

_____

Is there anything else we need to know to better assist you?
_____

_____

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**Signatures**

_____
Client Printed Name

_____
Client Signature

_____
Date

_____
Therapist Printed Name, Credentials

_____
Therapist Signature

_____
Date