



PASTORAL COUNSELING
FOR DENVER

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Denver, CO 80237
Phone: 303-741-5588
Fax: 303-741-9977
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AGENCY RECORD

Date _____

Name _____ Social Security # _____

Street Address _____ City _____

Zip Code _____

Birth Date _____ Sex _____

Cell Phone _____ Home Phone _____

WorkPhone _____ OK to leave msg on Cell? – Y/N on Home? – Y/N on Work? – Y/N

Email _____

Emergency Contact Person _____ Relationship? _____

Emergency Contact's Phone # _____

Occupation _____ Grade Completed _____

Spouse _____ Occupation _____

Date of Marriage/Divorce _____

Children (Names / Ages / Dates of Death)

Father _____ Occupation _____

Mother _____ Occupation _____

Siblings (Names / Ages / Dates of Death)

Former Marriages

(Dates) _____

Church _____

Pastor _____

Other important persons _____

Previous Counselors _____

Physician _____ Medications now used _____

Significant Illnesses / Injuries / Physical Conditions / Hospitalizations / Etc in Your Life (Dates)

Recent Changes in Your Life _____

Statement of Problem _____

For Treatment Planning

Types of Counseling Desired: _____ Individual _____ Marital _____ Family _____ Group

What motivated you to seek therapy now? _____

Please rate your level of distress in the relevant areas below. Use the following numbers to rate your distress:

0 – None 1 – Very Little 2 – Little 3 – Moderate 4 – Considerable 5 – Very Considerable 6 – Maximum

- | | |
|-------------------------------------|--------------------------------------|
| _____ Depression | _____ Alcohol/other drug use (self) |
| _____ Suicidal thoughts | _____ Alcohol/other drug use(family) |
| _____ Suicidal actions | _____ Marital/relationship problems |
| _____ Anxiety | _____ Sexual problems |
| _____ Panic attacks | _____ Physical Abuse |
| _____ Sleep problems | _____ Legal difficulties |
| _____ Eating disorder | _____ Death of a loved one |
| _____ Withdrawn behavior | _____ Compulsive gambling |
| _____ Health problems | _____ Self-esteem problems |
| _____ Job related problems | _____ Career choice concerns |
| _____ Financial concerns | _____ Sexual abuse, actual |
| _____ Domestic violence | _____ Sexual abuse, threatened |
| _____ Parent-child conflict (self) | _____ Brother/sister problems |
| _____ Parent-child conflict (other) | _____ Blended family issues |
| _____ Communication problems | _____ Parental loss of control |
| _____ Other | _____ Spiritual health |

What goals do you want to accomplish in therapy?

Referral

How did you find out about our counseling services?

Who referred you? _____

Relationship _____

Address _____ Phone _____