Paula Stephani, LPC
1650 38th St. Suite 100E
Boulder, CO. 80301
720-608-6037

Client Intake Form

Name:_____

Address:_____

Phone:_____Email:_____

May I leave a message at this number? **Yes/No** Permission to text or email you? **Yes/No**

Date of Birth: _____ Relationship Status: _____

Reason for Seeking Therapy:_____

What are your goals for therapy?_____

Pre-existing physical or mental health diagnoses or concerns:_____

_____

Current Medications:_____

_____

Have you ever had suicidal thoughts? **Yes/No**

Have you been hospitalized for physical or mental health reasons? **Yes/No**

Have you been in therapy previously? **Yes/No**

Please list any past traumatic experiences you have had (including but not limited to childhood abuse, military combat, assault, natural disasters, life threatening illness):_____

_____

_____

Highest level of education completed:_____

Occupation:_____

Strengths and interests:_____

_____

Family of Origin (parents, siblings, deaths, any information you feel it is important for me to know)

_____

_____

Current relationships/living arrangements:_____

_____

_____

Over the last 4 weeks have you experienced any of the following?

____Irritability
____Fatigue
____Sleeping Too Much/Too Little
____Diminished self-esteem
____Nightmares
____Unhappiness
____Headaches
____Loneliness
____Depression
____Hallucinations
____Poor concentration
____Restlessness
____Excessive Guilt
____Thoughts of harming others
____Hopelessness
____Excessive Worry
____Tension
____Nervousness
____Stress
____Health Problems
____Sexual Problems
____Indecisiveness
____Confusion
____Eating Too Much/Too Little
____Mood Swings
____Angry Outbursts
____Thoughts of harming yourself

____Alcohol Use
Frequency:_____
Amount:_____

____Drug Use
Kind:_____
Frequency:_____
Amount:_____

EMERGENCY CONTACT RELEASE

I hereby authorize Paula Stephani, LPC to release information to the following person in the event of a medical or mental health emergency:

Emergency Contact Name and Relationship:_____

Phone Number:_____

For the purpose of: care during a medical or mental health (suicidal/homicidal) emergency or inability to contact to ascertain safety.

The information authorized to be released (please initial below):

_____Any information related to a medical concern or emergency

_____Any information needed to secure safety when suicidal, homicidal

_____Any information needed to establish safety if therapist is unable to contact or locate

I have been told that in order to protect the limited confidentiality of records, my agreement to obtain or release information is necessary and that this permission is limited to the purposes and to the person listed above, and will be effective for the duration of treatment with Paula Stephani. I also understand that this consent is revocable except to the extent that action has already been taken. I further understand that Paula Stephani will not condition my treatment on whether I give authorization for the requested disclosure.

_____ _____

Client Signature Date