Jessica Joiner, LCSW, LAC
Journey Inspired Counseling, PLLC
19751 E. Mainstreet #395 | Parker, CO 80138 | 303.895.0635

Confidential Client Information

Today's Date: _____

Name: _____
Please Call Me By (If different from given name/Nickname):_____
Birth date: _____ Age: _____ Identify as: Male / Female Race: _____
Identify as: Heterosexual / Lesbian / Gay / Bisexual / Transgender / Questioning /
or Do not wish to disclose
Preferred Pronouns: He/Him/His Her/She/Hers
Address: _____ City: _____ State: _____
Zip: _____ County: _____
Preferred Phone #: _____ Home or Cell?
E-mail Address: _____
Is it okay to leave a message on your telephone? Yes No
Is it okay to leave a message with another person? Yes No
If so, please name the person(s) and their relationship to you: _____

Relationship Status: Married Single Divorced Separated Domestic Partner
Do you have children? Yes No Do they live with you? Yes No
If yes, what are their ages and gender? _____

What is the highest grade you completed in school? _____
Where did you attend college and degree earned? _____
Place of Employment: _____ Profession: _____
Are you retired? Y / N If so, for how long? _____
Are you unemployed? Y /N If so, for how long? _____

Who referred you to my office? _____
May I thank them? Yes/No

Emergency Contact Name: _____
Relationship to you: _____
Contact Information: _____

Authorization to Treat:
I authorize and direct, Jessica Joiner, LCSW, CACIII (Colorado LCSW #0992544, CACIII #0006841) to perform such therapeutic services that the provider's professional judgment may indicate to be advisable for my well-being. I understand that no warranty or guarantee is made as to the results of this treatment.

_____

_____

Print Client Name Sign Client Name Date

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Name: _____ Date: _____

New Client History

Presenting Problem(s):

1. Briefly describe what brings you in today:
   _____
   _____
   _____
   _____
2. How long have you been experiencing this problem? _____
3. How has the problem interfered with your everyday life: _____
   _____

Medical History:

1. Please list any prescription and/or over the counter medication you are taking.

_____

Name of Medication **Dosage** **How Often**

_____

Name of Medication **Dosage** **How Often**

_____

Name of Medication **Dosage** **How Often**

2. Please list any serious medical conditions you are being, or have been, treated for:
   _____
   _____
3. Last Physical Exam: _____
4. Primary Care Physicians Name: _____

Mental Health History:

1. Have your ever received mental health treatment before? Yes No
2. Reason for treatment? _____
3. What type of treatment did you receive? Hospital Outpatient Both
4. When and how long were you in treatment? _____
5. Where were you in treatment? _____
6. Who was your therapist/doctor? _____

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Name: _____ Date: _____

7. Did he/she prescribe medicine? Yes No What type? _____
8. Did you take the medication(s) as directed? Yes No
9. Have you ever attempted suicide? Yes No Why/When/Method? _____
   _____
10. Are you contemplating suicide now? _____

Family History:

1. Did you have a relationship with your mother? Y/N
   Was she present in your childhood? Y/N
2. Did you have a relationship with your father? Y/N
   Was he present in your childhood? Y/N
3. Describe your relationship (both past and current) with each of your parents, or primary caregivers:
   _____
   _____
   _____
   _____
4. Describe any important emotional, medical, or substance abuse problems that your parent(s) or family member(s) have: _____
   _____
5. Do you have siblings? Y/N Names/Ages:_____
   _____
6. What birth order are you? _____
7. Describe your cultural background: _____
   _____

Substance Abuse History:

1. Have you ever abused street drugs, alcohol, or prescription medications? Yes / No
2. Please fill out the chart below for all substances you have ever used or are using currently:

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Substance	*Age of First Use*	*Used how many times/day or week*	*Average Amount used each time*	*For How long (months/years)*	*Route of Admission (orally, inhaling, smoking, injection)*	*Date of last use*
Alcohol						
Marijuana						
Tobacco						
Cocaine						
Methamphetamine						
Heroin						
Amphetamines						
Vicodin						
Oxycontin/codone						
Percocet						
Other prescription opioids						
Barbiturates						
PCP						
Hallucinogens						
Tranquilizers						
Inhalants						
Over the counter (Name):						

3. What do you consider your primary drug of choice? _____
   Secondary? _____
   Tertiary? _____

Drug Treatment History

1. Date of last Admission: _____ Date of last Discharge: _____ Number of Prior Admissions: _____
2. What was the type of treatment during your last admission? Inpatient/Outpatient/ Detox/ Other:_____
3. Outcome of last treatment episode: Completed Successfully / Not Complete
4. Have others in your life voiced concerns (past or present) about your substance use? Yes / No
5. Has your substance use negatively impacted one or more areas of your life? Y /N
   Briefly Explain: _____

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Name: _____ Date: _____

6. Do you have concerns about your substance use? Y / N Why? _____
   _____

Legal History:

1. Have you ever had any involvement with the legal or criminal justice system? Yes/ No
2. Briefly describe your involvement specifying charges and dates of incident(s):
   _____
   _____
3. Have you ever been charged with a DUI/DWAI? Y / N How many? _____
   Year of charge(s): _____ In what state(s): _____
4. Are you currently suing anyone or thinking of suing anyone? Yes / No
   Briefly explain:
   _____
   _____

Domestic Violence and Abuse History *as an Adult*:
Emotional/Mental in the past? Yes No Currently? Yes No
Physical Abuse in the past? Yes No Currently? Yes No
Sexual Abuse in the past? Yes No Currently? Yes No

Domestic Violence and Abuse History *as a Child*:
Emotional/Mental in the past? Yes No Age: _____
Physical Abuse in the past? Yes No Age: _____
Sexual Abuse in the past? Yes No Age: _____
Relationship of perpetrator(s) to you?
_____

Please list family, friends, support groups and community groups that are helpful to you:
_____
_____

Have you ever been in the military? Yes No If yes, please provide details (Branch, amount of time, type of discharge, etc.): _____
_____

Do you have easy access to any guns or weapons? Yes No If yes, please provide details: _____
_____

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Name: _____ Date: _____

Spiritual/Faith (please circle which is appropriate for you):
I attend church: Regularly / Never / Just a little / Pretty Much/ Very Much-- N/A
Prayer is important to me: Never / Just a little / Pretty Much / Very Much-- N/A
I am confident in my spiritual beliefs: Never / Just a little / Pretty Much/ Very Much-- N/A
My spiritual life is helpful to me: Never / Just a little / Pretty Much / Very Much-- N/A
Religious Affiliation in Childhood: _____ Currently: _____

Your Goals in Counseling:
Goals are very important in counseling because they provide us with a focus and direction to take in our sessions. Please list the goal(s) or changes that you hope to address and achieve in counseling. Please be as specific as possible.

1. _____
   _____
2. _____
   _____
3. _____
   _____