Colorado Center *for*
Assessment & Counseling
KNOWLEDGE *to* THRIVE

*phone* 970-889-8204
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*office* 343 W. Drake Rd.
Suite 200
Fort Collins, CO 80526

## General Information

Date: ______________________ Date of Birth: _____________________Age: _______________________

Full Name: ______________________________________________________________________________

Address (include zip): _____________________________________________________________________

Phone: Home: ________________ Is it okay to leave a detailed message at this number? Yes __ No __

Cell: __________________ Is it okay to leave a detailed message at this number? Yes __ No __

E-Mail Address: __________________________________________________________________________

Do I have your consent to email an appointment reminder prior to sessions? Yes _____ No _____

Do I have your consent to email digital copies of:

1) Records: Yes _____ No _____

2) Billing statements: Yes _____ No _____

Emergency contact name: __________________________________________________________________

Phone #: __________________________ Email Address: ________________________________________

**Please tell us a little more about you:**

Gender: ________________________________________________________________________________

Ethnicity/Cultural identity: _________________________________________________________________

Spiritual beliefs: __________________________________________________________________________

Disability (if any): _________________________________________________________________________

Sexual orientation: ________________________________________________________________________

Occupation and/or School & Major: _________________________________________________________

Handedness (right/left/ambidextrous): _______________________________________________________

Who referred you to our service? Please provide contact information: ______________________________

_______________________________________________________________________________________

Is this referral a result of or related to any legal or court proceedings? If so please provide name of attorney.

_______________________________________________________________________________________

Please list the reason(s) you are seeking services:

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

How long have these problems occurred? (number of weeks, months, years)________________________

Please list any other healthcare providers involved in your care (e.g., neurologists, other physicians, occupational therapists, etc.): ________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

**Developmental/Medical History**

Medical History

**Yes No** Has your medical history been normal/unremarkable? If no, please explain: ______________
______________________________________________________________________________
______________________________________________________________________________

**Yes No** Have you received any medical diagnoses? Please explain: ______________________________
______________________________________________________________________________
______________________________________________________________________________

Have you ever been hospitalized, had surgeries, or major illnesses?

| *Age* | *How long* | *Reason* |
| --- | --- | --- |
| _______ | ______________ | ________________________________________________ |
| _______ | ______________ | ________________________________________________ |

What medications do you currently take? (Include over-the-counter supplements)

| *Name* | *Dose* | *Frequency* | *Reason* |
| --- | --- | --- | --- |
| _______ | ______________ | ______________ | ______________________________ |
| _______ | ______________ | ______________ | ______________________________ |

Describe your sleep routine:
Typical bed time: ____________ Typical wake time: ___________
Trouble falling asleep? **Yes No** Trouble staying asleep? **Yes No** Trouble waking up early? **Yes No**
Any other sleep problems? Explain: ________________________________________________
______________________________________________________________________________

Describe your diet: ____________________________________________________________
______________________________________________________________________________

Describe your current level and type(s) of exercise: ______________________________________
______________________________________________________________________________
______________________________________________________________________________

Mental Health History

List any previous or current mental health diagnoses:____________________________________
______________________________________________________________________________

Have you received therapy services or counseling in the past? **Yes** **No**
Name of provider:________________________________________ Dates:______________________
Name of provider:________________________________________ Dates:______________________
Name of provider:________________________________________ Dates:______________________

Are you currently seeing a psychiatrist for medication? **Yes** **No** Have you in the past? **Yes** **No**
Name of Psychiatrist:______________________________________ Dates of treatment:_________________
Medication the Psychiatrist Prescribed:__________________________________________________

 Revised 11/22/16

Is there a history of self-harm or suicidal thoughts, threats, or attempts? Please explain: ______________
________________________________________________________________________________

Have you ever been hospitalized for mental health concerns? Please explain:________________________
________________________________________________________________________________

## Psychosocial Functioning

Describe your personality: ______________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

What are your non-academic strengths?
________________________________________________________________________________

What are your non-academic weaknesses?
________________________________________________________________________________

How do you spend your free time?
________________________________________________________________________________
________________________________________________________________________________

What is your current level of alcohol and/or drug use?
Alcohol: _______________________________________________________________________
Recreational drugs: ______________________________________________________________

How is your social group? Do you have close friends? Any trouble initiating or maintaining relationships?
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

**Please place a mark next to behaviors that you believe you experience to an *excessive or exaggerated degree*.**

*Sleeping and Eating*

- ❑ Nightmares
- ❑ Trouble falling asleep
- ❑ Trouble staying asleep in the morning
- ❑ Decreased need for sleep without getting tired
- ❑ Eats Poorly
- ❑ Eats excessively
- ❑ Excessive snoring during sleep

*Social*

- ❑ Prefers to be alone
- ❑ Excessively shy or timid
- ❑ More interested in objects than people
- ❑ Difficulty making friends
- ❑ Not sought out for friendship by peers
- ❑ Excessive daydreaming and fantasy life
- ❑ Difficulty seeing another person's point of view
- ❑ Trouble empathizing with others
- ❑ Overly trusting of others
- ❑ Trouble understanding/enjoying humor

*Behavior*

- ❑ Stubborn
- ❑ Irritable, angry, or resentful
- ❑ Strikes out at others
- ❑ Throws or destroys things
- ❑ Lying
- ❑ Stealing
- ❑ Argues with others
- ❑ Low frustration threshold
- ❑ Daredevil behavior
- ❑ Impulsive (does things without thinking)
- ❑ History of vocal or motor tics
- ❑ Poor sense of danger/risk
- ❑ Cries frequently
- ❑ Excessively worried and anxious
- ❑ Overly preoccupied with details
- ❑ Overly attached to certain objects
- ❑ Not affected by negative consequences
- ❑ Drug abuse
- ❑ Alcohol abuse

*Motor Skills*

- ❑ Poor fine motor coordination
- ❑ Poor gross motor coordination
- ❑ "Clumsy" in general

## Legal History

Have you been involved with the court currently or in the past? ____________________________________

Date(s): ____________________________________________________________________________________

Describe: ___________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Current Probation? **Yes** **No** Probation Officer: ______________________ Phone #:____________________

## Family History

Are you (choose one): **Married** **Separated** **Divorced** **Living Together** **Single**

If married, for how long? ___________________________________________________________________

If separated or divorced, when? _____________________________________________________________

Do you have children? Ages? _________________________________________________________________

Who else lives in your home? ________________________________________________________________

_____________________________________________________________________________________________

Have any of the following diseases occurred among your blood relatives (parents, aunts, uncles, grandparents)? Check those that apply:

- ❑ Allergies
- ❑ Amnesia
- ❑ Asthma
- ❑ ADHD
- ❑ Bleeding tendency
- ❑ Depression
- ❑ Cancer
- ❑ Suicide
- ❑ Learning problems
- ❑ Deafness
- ❑ Diabetes
- ❑ Glandular problems
- ❑ Heart diseases
- ❑ High blood pressure
- ❑ Kidney disease
- ❑ Alcohol/drug problem
- ❑ Anxiety
- ❑ Autism/Asperger's
- ❑ Intellectual disability/cognitive delay
- ❑ Seizures
- ❑ Cerebral Palsy
- ❑ Migraines
- ❑ Muscular Dystrophy
- ❑ Other (specify): ____________________