



Kathy Higgins

KATHY HIGGINS LPC LLC

Kathleen Higgins, MS, MA, LPC, LAC, EMDR, NCC

5912 S. Cody St., Suite 302

Littleton, CO 80123

720-663-7702

CONFIDENTIAL CLIENT INFORMATION

Name: _____ DOB: _____ Age: _____

Address: _____

Phone Home: _____ Work: _____ Cell: _____

Please circle phone number(s) where messages can be left.

E-mail: _____ Okay to send general emails? YES NO

Type of Counseling: Individual: _____ Couple: _____ Family: _____ Other: _____

Relationship Status:

_____ Single _____ Married _____ Divorced _____ Separated _____ Widowed _____ Partnered

Name of Spouse/Partner _____ Phone _____

Does he/she know you are seeking counseling? YES NO

In Case of Emergency, contact _____

Address _____ Phone _____

Spiritual Path _____ Level of Involvement? High Med Low

Is this an important part of your life? _____ Why/why not? _____

Physical History(please be accurate, medical records may need to be disclosed at some point)

General Health_____

Are you under a doctor's care?_____ If yes, name of doctor_____

Reason for doctor's care_____

Are you taking any medication?_____ If yes, what kind?_____

Reason for medication_____ Last medical examination_____

Have you ever been hospitalized for a physical illness?_____ Describe_____

Have you ever been hospitalized for a mental illness?_____ Describe_____

Any recent major illnesses or surgeries?_____

Any recurrent or chronic conditions or injuries?_____

Any Previous Therapy/Counseling?_____ If yes, describe, when, where, how long, what
for_____

Work History Occupation_____ How long?_____

If presently unemployed, describe the situation_____

Hobbies/Sports_____

Family Information

Place of Birth_____ Ethnicity_____ Race_____

Parents: Father:_____ Where residing_____ Relationship_____

Mother_____ Where residing_____ Relationship_____

Do you have Children? YES NO

#1 M F Age_____ #2 M F Age_____ #3 M F Age_____ #4 M F Age_____ #5 M F Age_____

Do you have Siblings YES NO Circle your place in the family.

#1 M F Age_____ #2 M F Age_____ #3 M F Age_____ #4 M F Age_____ #5 M F Age_____

Family Alcoholism or Domestic Violence_____

Sexual Addictions or Abuse? _____

Parents divorced? _____ If yes, what year _____ Your age at the time _____

Step-parents? _____ Describe relationship with them _____

Emotional Status

Are you currently experiencing strong emotions? _____ If yes, describe _____

Have you experienced what you would consider to be trauma? _____ Please describe _____

Present Situation

Please state why you decided to come for counseling now _____

How long has this been a problem for you _____

Please state what you would like to work on in therapy _____



Kathy Higgins

Personal Agreements

I understand that I may be asked to do certain “homework exercises” such as reading, journaling, exercising, changing behaviors, and otherwise acting in my own best interest. I understand that I am entirely responsible for my own actions and I will always make my own final decisions regarding counseling.

I further understand that much of the work done will be to resolve issues and will depend on my honesty, and willingness to do the things I need to do to move forward even if it is painful and difficult.

I have read the preceding information and understand my rights as a client. I consent to treatment with this therapist.

Client Signature

Date

Printed Name

Date

Witness, Parent or Client Signature (if appropriate)

Date

Kathleen Higgins dba Kathy Higgins LPC LLC

Date