Joni Zepp, MA, RN, CAC III, LPC
614 N. Nevada Avenue, Suite 201
Colorado Springs, CO 80903
719-593-8876 www.joannzepp.com

Office Use Only

____

____

Client Information Form

General Information

Full name:____ Date:______________

Date of birth: ____ Age: ______________

Home address:_____________________________________ Suite/apt number____________

City: ______________________________________State__________Zip code ____________

Home phone(_____)______________________________May I leave a message here □Yes □No

Cell phone (_____)______________________________May I leave a message here □Yes □No

Work phone (_____)______________________________May I leave a message here □Yes □No

e-mail address____

Insurance company __________________________________ Phone(_____)_____________

Primary sponsor's name _______________________ Relationship to client: ______________

Subscriber ID# ____________________________Insurance group #_____________________

Insurance claims address____

Emergency Contact

Name________________________ Relationship________________ Phone ______________

Referred by:____

Employment and Education

Employer _____________________________________ Length of employment____________

Occupation__________________________________ Average hours worked per week_______

Last year of school completed: High school______College_________Grad school___________

Are you currently in school □Yes □No If yes, degree pursuing___________________________

Relational Information

Current relational status: □ Single □ Married □ Separated □ Divorced □ Widowed

Spouse's Name ______________________ Age______________________________

Spouse's occupation____

Average hours worked per week____

Were you previously married_______________________ Were you adopted__________

Children

Name	Age	Deceased?	Relationship to You (natural, step, adopted, etc.)	Describe Him or Her

Have you ever placed a child for adoption □Yes □No If yes, when: ___________________

Have you ever had a miscarriage or abortion □Yes □No If yes, when____________

Family of Origin

Name	Age	Deceased?	Relationship to You (mother, father, sibling, etc.)	Describe Him or Her

Medical Information

Primary physician _____________________________ Phone (_____)____________

Specialist____ Phone(_____)____________

Are you currently receiving medical treatment □Yes □No If yes, please specify

____

____

____

_

List any relevant medical conditions, illnesses, surgeries, traumas or related treatments you have had: ____

____

Medications

List any current medications you are taking (use back if necessary):

Medication__________________________ Purpose_________________________________

Medication __________________________Purpose_________________________________

Medication __________________________Purpose_________________________________

Medication___________________________Purpose________________________________

Medications discontinued in past year: ____

____

How often do you engage in recreational drug use?

If yes, which drugs?____

__Daily __Weekly __Monthly __Infrequently _Never

Do you use CBD? If so, how often?

____

Level of Distress

Describe your level of distress____

Are you currently experiencing any suicidal thoughts □Yes □No

Have you experienced them in the past □Yes □No

Have you ever attempted suicide □Yes □No If yes, when and how_________________________

____

Have any of your friends or family ever committed or attempted suicide □Yes □No

If yes, when and who ____

Spiritual Background

Please describe your spiritual beliefs ____

____

Do you regularly attend a place of worship □Yes □No If yes, where______________________

What words would you use to describe yourself_____________________________________

____

Words to describe how you see your identity____

Previous Counseling

List any previous counseling, psychiatric treatment, or residential/in-patient care you have received (use back if necessary)

Therapist________________Location___________Dates__________Reason______________

Therapist________________Location___________Dates__________Reason______________

Presenting Issues and Goals

Please describe why you are coming to counseling (i.e. What are your issues, problems?)

____

____

____

What do you hope to gain or change by coming for counseling __________________________

____

PROBLEM	**SERIOUSNESS OF PROBLEM**				
	Not at all		Somewhat		Extremely
Communication	1	2	3	4	5
Grief and loss	1	2	3	4	5
Marriage	1	2	3	4	5
Depression	1	2	3	4	5
Emotional intimacy	1	2	3	4	5
Anxiety/fears	1	2	3	4	5
Issues with eating	1	2	3	4	5
Alcohol and/or drugs	1	2	3	4	5
Children	1	2	3	4	5
Hurtful relationship	1	2	3	4	5
Trauma	1	2	3	4	5
Meaning & purpose	1	2	3	4	5
Spiritual concerns	1	2	3	4	5

Is there anything else you would like me to know about you that would be beneficial to your therapy?

____

____

____

Terms of Service

I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of intention to cancel, I will be charged a $50.00 fee.

____ ___________________________

Client signature Date

____ ___________________________