New Beginnings Psychological Resources
PO Box 440763 ~ Aurora, Colorado
80044-0763
(303) 777-5536

Protected Health Information (PHI)

TODAY'S DATE

PERSONAL INFORMATION		
Last Name	**First Name**	**Middle Initial**
Street Address		**Apt. Number**
City	**State**	**Zip Code**
Home Phone Number:	**Cell Phone Number:**	**Email address:**
Birth Date: _____ Month / Day / Year	**Marital Status:**	**Social Security Number:** – –

EMPLOYMENT INFORMATION		
Name of Employer		**Occupation**
Street Address		
City	**State**	**Zip Code**
Work Phone Number **Ext:**	**May we call you at work?** ☐ **Yes** ☐ **No**	

FOR OFFICE USE ONLY
DSM 5
☐ ACCOUNT # _____
FEE $ _____
INSURANCE? _____

MEDICAL INFORMATION	
Physician's Name	**Phone Number**

PLEASE LIST ALL MEDICATIONS YOU ARE NOW USING

Name of Medication	Presc / OTC	Dose	Times per day

COUNSELING INFORMATION
Do you feel that you are currently in crisis and could harm yourself or someone else? ☐ **Yes** ☐ **No**
WHAT IS YOUR REASON FOR SEEKING COUNSELING AT THIS TIME?

New Beginnings Psychological Resources
PO Box 440763 ~ Aurora, Colorado
80044-0763
(303) 777-5536

Confidential Information Form

CLIENT'S NAME	TODAY'S DATE

FAMILY INFORMATION

CURRENT MARRIAGE

Spouse's First Name:	Spouse's Last Name:	M.I.

Date of Marriage: _____ Month / Day / Year	Length of Engagement:
Spouse's Employer:	Work Phone:

Children by this relationship:

Name	Sex	Birth Date	Current Age	Living at home?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

PREVIOUS MARRIAGE / RELATIONSHIP

Partner's First Name:	Partner's Last Name:

Date of Marriage (or beginning of cohabitation): _____ Month / Day / Year	Your age at that time:

Length of Engagement:	Date of Divorce:	Date(s) Separated:

Children by this relationship:

Name	Sex	Birth Date	Current Age	Living at home?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Please ask therapist for additional marriage data pages if necessary to list other marriages / relationships.

FAMILY INFORMATION

FAMILY OF ORIGIN

Birth Father:	Birth Mother:
Father's Occupation:	Mother's Occupation:

Adoptive and / or Step Parents:

Brothers and / or Sisters:

Name	Sex	Birth Date	Current Age	Marital Status

PSYCHIATRIC HISTORY

Is there a history of addictions and / or mental illness in any of your blood relatives? If so, please describe:

Have you seen a counselor / therapist previously? If so, when, how long, and for what reason?

Have you been hospitalized for psychiatric reasons? If so, when, how long, and for what reason?

MEDICAL HISTORY

Have you been hospitalized for medical reasons (surgery, etc.)? If so, when and for what reason?

GENERAL INFORMATION

Have you experienced any of the following in your lifetime?

Physical abuse	☐ **Yes**	☐ **No**	**Dates**
Emotional abuse	☐ **Yes**	☐ **No**	**Dates**
Sexual abuse	☐ **Yes**	☐ **No**	**Dates**
Victim of violent crime	☐ **Yes**	☐ **No**	**Dates**
Concussion / Unconscious	☐ **Yes**	☐ **No**	**Dates**
Seizures / Dizziness	☐ **Yes**	☐ **No**	**Dates**
Suicide attempts	☐ **Yes**	☐ **No**	**Dates**
Legal problems	☐ **Yes**	☐ **No**	**Dates**

What is your current usage of the following?

	Average number of days used in last month	**Average amount used on each occasion**
Alcohol		
Non-prescription drugs		

Has your usage gone up or down in the last six months?

Do you have any questions you would like me to answer at this time about my practice, your Protected Health Information (PHI), or any other matter?