Allison C. Gary, MA, LPC, NCC
300 S. Jackson St. suite 200
Denver, CO 80209
AllisonCGary@gmail.com
Direct: 720-619-1058

ACG Counseling Services LLC

Counseling Intake - Adult

Full Name:_____ Today's Date:_____

Date of Birth:_____ Pronouns:_____

Address:_____

Phone:_____

☐ OK to call this phone number, ☐ OK to leave a voicemail, ☐ OK to text this phone number

Email:_____☐OK email me at this address

Employment Status:_____ Job Title *(if applicable)*:_____

Do you have insurance? YES NO If yes, who is your insurance provider?_____

☐ I understand that you do not accept insurance at this time.

Observed Symptoms:_____

What are some of your greatest strengths?_____

Goals for Counseling:_____

Emergency Contact: *In the event that an emergency arises, what is the name and phone number of someone that we may contact?*_____

_____

Family Composition and Relationships

Please describe home life and dynamics within your family.

_____

_____

Who lives in the home with you?_____

_____

Current relationship status:_____ Any Pets? YES NO

Friendships: Many Friends Some Friends Few to No Friends

Any concerns within your familial or social relationships? YES NO

If yes, please describe:_____

Any current or past pregnancies? YES NO

Residential moves/relocations?_____

Any other life transitions you have experienced *(divorce, birth, death, other losses, changes with work/school, relationship changes, etc.)*_____

_____

If death of family member/friend(s), who and when:_____

Tell me a little more about what happened/the circumstances of the death(s)?:_____

_____

Were you present for the death? YES NO

Have you received any support regarding this death loss? YES NO

If so, what type of support and what was that like for you?_____

_____

Health History:

How would you describe your current overall health in general? EXCELLENT GOOD FAIR POOR

In the past year, have you experienced difficulty with any of the following areas? *(Circle all that apply)*

Relationships	Family	School	Health	Grief/Loss
Friendships	Spirituality	Anger	Legal	Mood
Anxiety	Eating Habits	Alcohol	Drugs	Smoking
Sexual/Sexuality	Aggression	Impulsiveness	Hopelessness	Life Transitions
Depression	Loneliness	Identity	Sleeping Habits	Stress Management

Have you or a member of your family experienced any of the following health conditions?

*Circle those that apply to you, put a star * next to those that apply to a family member.*

Addiction	Alzheimer's/Dementia	Asthma/Allergies	Birth Defects
Blindness/Vision Loss	Cancer	Deafness/Hearing Loss	Developmental Delays
Diabetes	Eating Disorders	Emotional Abuse	Heart Disease
High Blood Pressure	High Cholesterol	Homicidal Ideation	Learning Disorders
Mental Health Disorder	Obesity	Physical Abuse	Psychological Abuse
Rape/Sexual Assault/Abuse	Sleep Disturbances	Stroke	Suicidality
Surgeries	Trauma	Traumatic Brain Injury	Violence

Are you currently feeling suicidal? YES NO Are you currently feeling homicidal? YES NO

If yes, please explain:_____

If "Trauma" is circled or starred above, please briefly explain:_____

_____

Please share any safety issues such as violent behavior that are a concern:_____

_____

Have you previously or are you currently receiving other mental health services? YES NO

If so, what was that experience like?_____

Do you attend regular Doctor/Dental/Vision checkups? YES NO Date of last medical exam:_____

Current medical provider:_____

Are you currently taking medications? YES NO

If so, what medication and reason for taking?_____

Is there any other relevant health information you want me to know?_____

_____

Your Lifestyle:

Please describe your lifestyle including habits, hobbies, exercise/diet/nutrition, culture, religious/spiritual

_____

_____

What is self-care like for you?_____

_____

Is there anything else that you would like me to know?_____

_____

_____ _____

Client Signature **Date**

Thank you for taking the time to complete this form!