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## INFORMATION SHEET

Name: \_\_\_\_\_  
Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_  
Child's name (if client): \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: (h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_  
Nearest Relative Not Living With You: \_\_\_\_\_  
Their Address and Phone Number: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Their Address: \_\_\_\_\_  
Their Phone:(h): \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_  
Referred to me by: \_\_\_\_\_

During our first few sessions I would like to have a chance to get to know you and hear what kinds of things you would like to focus on during our time together. I will also ask about a few aspects of your life that may not seem directly connected to the topics you bring up, but that might turn out to be important later on. By answering the questions below, you can help me to make sure I am not missing out on some things that could help your progress toward your goals.

### ***Personal Background:***

Ethnic/cultural background: \_\_\_\_\_  
Current spiritual/religious identification: \_\_\_\_\_  
Ever had counseling in the past? \_\_\_\_\_ For? \_\_\_\_\_  
Ever received a formal psychological evaluation? \_\_\_\_\_ Diagnosis: \_\_\_\_\_  
Currently involved in any legal action? \_\_\_\_\_ Regarding? \_\_\_\_\_

### ***Living situation:***

Marital status (check all that apply):  single  living with a partner  married  
 separated  divorced  widowed

Who do you live with and what is each person's relationship to you? \_\_\_\_\_  
\_\_\_\_\_

**Employment:**

Employment status (check all that apply):  full time student  part time student  
 unemployed  homemaker  retired/pensioner  receiving government assistance  
 working 30+ hours a week  working less than 30 hours a week

Occupation (current or past): \_\_\_\_\_

Employer: \_\_\_\_\_ Employer's address: \_\_\_\_\_

Approximate annual household income: \_\_\_\_\_

Current hobbies/interests: \_\_\_\_\_

**Health:**

Current health concerns: \_\_\_\_\_

Current medications: \_\_\_\_\_

Name of Your Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Additional doctors prescribing medication to you: \_\_\_\_\_

How often do you exercise? \_\_\_\_\_ Date of last medical check-up: \_\_\_\_\_

How many units of alcohol do you have per week (beer/glass of wine/shot)? \_\_\_\_\_

Which drugs have you used in the past 6 months: \_\_\_\_\_

Ever think of physically harming yourself or committing suicide? \_\_\_\_\_ Currently? \_\_\_\_\_

Ever think about physically harming other people? \_\_\_\_\_ Currently? \_\_\_\_\_

Do you currently feel threatened or in danger of being physically or emotionally harmed by another person? \_\_\_\_\_

What else might be helpful for me to know?

What is your reason for seeking counseling at this time?

What do you hope to accomplish from participating in therapy?