Nicholas Simpson,
Counseling MA, LPC

80 Garden Center, Suite 250
Broomfield, CO 80020
720-254-3050

Personal/Contact Info:

Client Name: _____ Date: _____
Date of Birth: _____, Gender (M/F): _____
Spouse or Child's Name (if client): _____ DOB: _____
Address/ City/ Zipcode: _____
Phone:(h) _____ ._____._____, (w) _____ ._____._____, (c) _____ ._____._____
Email: _____, Private or Shared? _____
Nearest Relative Not Living With You: _____
Their Address and Phone #: _____
Emergency Contact:_____ , Relationship: _____
Emergency Contact's Address:_____
Their Phone: (h)____ - _____ - _____, (c) ____ - _____ - _____ , (w) ____ - _____ - _____
Referred to me by: _____

During our first few sessions I would like to have a chance to get to know you and learn what things you wish to focus on during our time together. I consider aspects of your life that may not seem directly connected to counseling, but that may be relevant later. The information requested below may assist me when considering things that may help your progress toward your goals.

Personal Background:

Ethnic/Cultural background:_____
Current Spiritual/Religious identification:_____
Previous Counseling (Dates Received) _____, For? _____
Previous Psychological Evaluation? (Y/N) _____, Date & Diagnosis:_____
Current involvement in legal actions? (Y/N) _____, Regarding?_____

Living Situation:

Marital status (check all that apply): __ Single, __ Living with a partner, __ Married
__Separated, __Divorced, __Widowed
Who do you live with? (Provide all Names & your Relation to each person)
_____, _____
_____, _____
_____, _____

Employment:

Employment status (check all that apply): __ Full-time Student, __ Part-time Student
__ Unemployed, __ Homemaker, __ Retired/Pensioner, __ Receiving Government Assistance

__ Working 30+ hours per week, __Working less than 30 hours per week

Occupation (current or past):_____
Employer: _____ , Address:_____
Approximate Annual Household Income:_____

Current Hobbies/Interests:_____

Health History:
Current Health Concerns:_____
Current Medications:_____
Name of Your Physician:_____Phone:_____
Physician's Practice Name & Address:_____
Additional Doctors prescribing medication to you:_____
Frequency & Types of Exercise?_____
Date of last Medical Check-up:_____

Substance Use History:
How many units of alcohol do you have per week (beer/glass of wine/shot)?_____
Drugs you have used in the past 6 months: _____
Have you ever been treated for Substance Dependence or Addiction? (Y/N) _____

Mental Health History:
Have you ever thought about physically harming yourself or committing suicide?_____
Do you currently have these thoughts?_____
Have you ever thought about physically harming other people?_____
Do you currently have these thoughts?_____
Do you currently feel threatened or in danger of being physically or emotionally harmed by another person?_____

Other Information
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 by participating in therapy?