Aspen Counseling Services

Date: ________________

Client Name: __________________________________ Gender: Male____ Female ______

Address: ______________________________________ DOB: ___/ ___/ ______ Age: _______

City/State: ______________________ Zip Code: ______ Contact Phone: __________________

Email Address: ___________________________________ Appointment Reminders: Yes or No

Employment Status: Student: ____Employed: ____ Unemployed:____Homemaker:_____ Retired:_____

Employer: ______________________________________ SSN: _____________________________

Occupation: ____________________________________ Business Ph: _______________________

Marital Status: (Circle one) Single Married Separated Divorced Widowed Other

Number of children: ____________

Spouses Name: ________________________________ DOB:___________ Age: _______

Spouses Employer: ____________________________ SSN: ___________________________

Spouses Occupation: ____________________________ Business Ph: _____________________

(fill out of client is a minor)

Father's Name: _________________________________ DOB: ___________ Age: ________

Employment Status: Student: ____Employed: ____Unemployed:____Homemaker:_____ Retired:_____

Employer: ______________________________________ SSN: _____________________________

Occupation: ____________________________________ Contact Ph: _______________________

Mother's Name: _________________________________ DOB: ___________ Age: _______

Employment Status: Student: ____Employed: ____Unemployed:____Homemaker:_____ Retired:_____

Employer: ______________________________________ SSN: _____________________________

Occupation: ____________________________________ Contact Ph: _______________________

Stepparent(s) Name(s):____________________________ Contact Ph: _______________________

Stepparent(s) Name(s):____________________________ Contact Ph: _______________________

Insurance Information *(Please fill out)*

Employee Assistance Program (EAP) Yes____No _____ If yes, please list EAP name: _______________

Authorization Number: ________________________ Number of Sessions: _______________________

Primary Insurance: ______________________________ Member ID: ___________ Group #: _________

Insured's Name: ________________________________ DOB: ____________ Gender: Male or Female

Secondary Insurance: ___________________________ Member ID: __________ Group #: __________

Insured's Name: ________________________________ DOB: ____________ Gender: Male or Female

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Number of Siblings: ____ What is your birth order position: _____ Highest Education Completed: ______

Primary Physician: ___________________________ Phone Number: ___________________

What is your primary reason for seeking help? ____

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Previous Treatments (check all that apply):

Psychiatric: None____Outpatient ____ Inpatient____
within last 12 mos ___ One prior admission ___ 2 or more admissions___
Counseling: yes ____ No_____ Where:________________________ When:________________

Current Symptom Checklist (check once for any symptom present):

Depressed Mood ____	Elevated Mood ____	Dissociative States ___
Decreased Energy ___	Irritable ____	Oppositional ___
Grief ___	Impulsivity ____	Somatic Complaints ___
Hopelessness ____	Hyperactivity ____	Emotional Trauma ____
Worthlessness _____	Disruption of Thought ____	Physical Trauma ____
Guilt ____	Memory problems ____	Sexual Trauma ____
Anxious ____	Delusions ____	Active Substance Abuse ___
Panic Attacks ____	Hallucinations ____	Other ____
Obsessions/Compulsions ____	Paranoia ____	Other ____

Risk Assessment (check all that apply):

Suicidal: Not Present ____ Ideation ____ Plan ____ Means ____ Prior Attempt ____ Date ______

Homicidal : Not Present ____ Ideation ____ Plan ____ Means ____ Prior Attempt ____ Date _____

Current Psychiatric Medications: Current medications and dosages

Family Mental Health History (Please put an X in the column)

	Mother	Father	Sibling	Other (List)
Anxiety				
Depression				
Bipolar Disorder				
Substance Abuse				
Other				

NAME:____ DATE:_____________________

GAD-7 (Please circle the number in each column)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not At All**	**Several Days**	**More Than Half the Days**	**Nearly Every Day**
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about differ things	0	1	2	3
Trouble Relaxing	0	1	2	3
Becoming so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful may happen	0	1	2	3

_______ + _______ + _______

For office coding: Total Score [ ]

The Patient Health Questionaire PHQ-9 (Please circle the number in each column)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not At All**	**Several Days**	**More Than Half The Days**	**Nearly Every Day**
Little interest or pleasure in doing things?	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself- or that you've let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or, the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

_______ + _______ + _______

For office coding: Total Score [ ]