

## Bear Valley Counseling Center Intake Form

The following information is needed to best help you. Please print your responses clearly.  
Gray boxed areas, or areas you cannot answer, are to be completed by/with your counselor.

Case records are strictly confidential.

### SECTION I: IDENTIFYING INFORMATION

Today's Date \_\_\_/\_\_\_/\_\_\_ Intake Counselor: \_\_\_\_\_ Assigned to: \_\_\_\_\_

Contact First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: *Please check preferred contact phone number.*

Home \_\_\_\_\_  Work \_\_\_\_\_  Cell \_\_\_\_\_

E-mail Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender: F M Ethnicity \_\_\_\_\_

Single  Engaged  Married  Divorced  Separated Years Married? \_\_\_\_ No. of Children \_\_\_\_

Family Members Currently Living In Home		
Full Name	Relationship	Age

Employer \_\_\_\_\_ Salary \_\_\_\_\_

### Spouse, Child or Person in Counseling with Client *(if applicable)*

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Ethnicity \_\_\_\_\_

Employer \_\_\_\_\_ Salary \_\_\_\_\_

### Emergency Information

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Church Home: \_\_\_\_\_ City \_\_\_\_\_

Attendance:  Weekly  2x/Month  Monthly  Other \_\_\_\_\_

How did you hear about Bear Valley Counseling Center? \_\_\_\_\_

Therapist Preference:  Male  Female  No Preference Name \_\_\_\_\_

Payment Structure:  Self Paid  Church Partnership  Insurance \_\_\_\_\_

Fee Scale/Session:  \$35  \$55  \$75  \$95 Method:  Cash  Check  Credit Card

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Bear Valley Counseling Center

12344 W. Alameda Parkway, Lakewood, Colorado 80228 303-763-9367

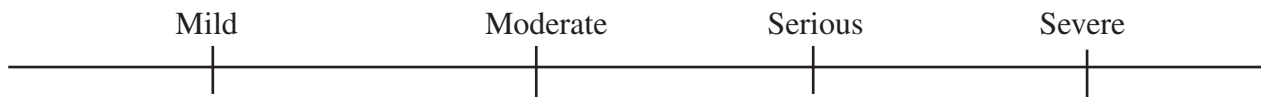
**SECTION II: DESCRIPTION OF PRESENTING PROBLEM**

Why did you decide to seek counseling: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What you want to work on while in counseling: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long has this been a significant problem for you? Please be specific (i.e., not “all my life”). \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How would you estimate the severity of the problem at this time? (Place “X” on the line below)



What symptoms are you experiencing as a result of this problem? Please check all that apply:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> overeating               | <input type="checkbox"/> vomiting                 | <input type="checkbox"/> easily distracted         |
| <input type="checkbox"/> restless                 | <input type="checkbox"/> recent weight loss       | <input type="checkbox"/> fatigue/loss of energy    |
| <input type="checkbox"/> rapid heart rate         | <input type="checkbox"/> low motivation           | <input type="checkbox"/> chest pain                |
| <input type="checkbox"/> compulsive behaviors     | <input type="checkbox"/> muscle tension           | <input type="checkbox"/> sleeping patterns         |
| <input type="checkbox"/> taking drugs             | <input type="checkbox"/> distrust                 | <input type="checkbox"/> obsessions                |
| <input type="checkbox"/> depressed mood           | <input type="checkbox"/> appetite changes         | <input type="checkbox"/> problems with work        |
| <input type="checkbox"/> sweating                 | <input type="checkbox"/> aggressive behavior      | <input type="checkbox"/> housing problems          |
| <input type="checkbox"/> fears/phobias            | <input type="checkbox"/> outbursts of temper      | <input type="checkbox"/> relationship problems     |
| <input type="checkbox"/> odd behavior/thoughts    | <input type="checkbox"/> jumpy                    | <input type="checkbox"/> drinking alcohol          |
| <input type="checkbox"/> crying                   | <input type="checkbox"/> social withdrawal        | <input type="checkbox"/> financial problems        |
| <input type="checkbox"/> trembling or shaking     | <input type="checkbox"/> feeling of worthlessness | <input type="checkbox"/> pain                      |
| <input type="checkbox"/> anxiety                  | <input type="checkbox"/> nightmares               | <input type="checkbox"/> self-mutilation behaviors |
| <input type="checkbox"/> weight gain              | <input type="checkbox"/> dizzy or lightheaded     | <input type="checkbox"/> suicidal thoughts         |
| <input type="checkbox"/> difficulty concentrating | <input type="checkbox"/> emotional problems       | <input type="checkbox"/> other: _____              |
| <input type="checkbox"/> shortness of breath      | <input type="checkbox"/> stomach problems         | <input type="checkbox"/> other: _____              |

**SECTION III: MEDICAL HISTORY**

Name of Physician \_\_\_\_\_ Date of last physical exam: \_\_\_\_\_

Phone \_\_\_\_\_ Location of office \_\_\_\_\_

List any significant past or current health, medical, or psychiatric issues:

Dates	Problem	Treatment	Hospitalized? (Y/N)

Have you ever had treatment by, or are you currently seeing, a psychiatrist, psychologist, therapist, or counselor? Yes \_\_\_ No \_\_\_

Dates	Problem	Therapist	Helpful? (Y/N)

Have you ever been given a mental health diagnosis in the past from a mental health professional?

Yes \_\_\_ No \_\_\_ If yes, as you understand it, what is/was that diagnosis? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you ever been admitted into a mental health care facility? Yes \_\_\_ No \_\_\_

Dates	Name and Location of Facility

Have you ever attempted suicide? Yes \_\_\_ No \_\_\_ If yes, please explain.

\_\_\_\_\_  
 \_\_\_\_\_

Have any family members ever attempted suicide? Yes \_\_\_ No \_\_\_ If yes, please explain.

\_\_\_\_\_  
 \_\_\_\_\_

**SECTION IV: MEDICATIONS AND SUBSTANCES**

If applicable, please list all medications you are now taking or have taken in the past three months, including birth control pills, vitamins, herbs and supplements.

Medication	How Long Taken?	Prescribing Physician	Helpful (Y/N)

**Substance Intake** (if applicable)

Please list amount of daily **or** weekly (D/W) consumption of the following:

Coffee \_\_\_\_/\_\_\_\_ Soda \_\_\_\_/\_\_\_\_ Tea \_\_\_\_/\_\_\_\_ Cigarettes \_\_\_\_/\_\_\_\_

Alcohol \_\_\_\_/\_\_\_\_ Type: \_\_\_\_\_ Illegal Substance \_\_\_\_/\_\_\_\_ Type: \_\_\_\_\_

Do you use any of these substances to (check all that apply):

- Manage Stress   To Relax   To Change Mood   For Sleep

**SECTION V: FAMILY OF ORIGIN INFORMATION**

Family Members: Include Blended Family Members

Name	Age	Relationship	Deceased (Y/N)

Have any members of your family had problems with:

	Name	Relationship	Deceased (Y/N)
Drugs/Alcohol			
Depression			
Anxiety			
Mental Problems			
Physical Illness			

Who do you rely on for support: \_\_\_\_\_ Relationship \_\_\_\_\_

**NOTE: There is room on the following page** to tell us what else we should know to give you the best care.

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**Bear Valley Counseling Center, Inc.**

12344 W. Alameda Parkway, Lakewood, Colorado 80228 303.763.9367

**Sliding Fee Scale**

Bear Valley Counseling Center is committed to affordable counseling. Thanks to the generosity of Bear Valley Church and other individual supporters, we are able to offer the sliding fee scale based on gross annual family income. Our fee scale is as follows:

<b>Total Gross Annual Family Income</b>	<b>Fee per Session</b>
\$19,999 and below .....	\$35.00
20,000 – 34,999 .....	55.00
35,000 – 49,999 .....	75.00
50,000 and above .....	95.00

- Payment is expected at the beginning of each session.
- If you need to cancel an appointment, please give your counselor 48 hours notice. Missed appointments with less than 48 hours notice will be billed.
- If you encounter financial difficulties at any time during counseling, please discuss it with your counselor.

Your cooperation with these policies enables us to continue offering quality affordable counseling. Proof of income may be requested.

Name 1: \_\_\_\_\_ Fee: \_\_\_\_\_

Name 2: \_\_\_\_\_ (for spouse or other party)

I have received a copy of this fee schedule and agree to the financial terms stated above.

Signature of Client(s): \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

Church Home: \_\_\_\_\_