Luna Counseling Center

6000 East Evans Avenue . Building 1, Suite 255 . Denver, CO 80222

Main: 720-277-6125 . Fax: 720-763-9669 . www.LunaCounselingCenter.com

Individual Admission Form

This is a confidential questionnaire which will give me information that will be helpful in your treatment. If there are questions you would rather not answer, leave them blank. Feel free to use the backs of sheets or to attach extra sheets.

GENERAL INFORMATION

Name:_____Date:_____

Address:_____City:_____State:_____Zip:_____

Daytime Phone: _____ Okay to leave a message? Yes__ No__

Evening Phone:_____Okay to leave a message? Yes__ No__

Email address:_____ Birth date: _____

Emergency Contact (include phone number and relation to you): _____

_____

How did you find out about my services? _____

Occupation:_____

What made you seek therapy at this time?

What do you hope to achieve from therapy?

Which emotions do you feel are easiest for you to express?

Which emotions do you feel are most difficult for you to express?

How would you describe your religion/spiritual beliefs?

RELATIONSHIP INFORMATION

Current Relationship Status: __Married/Partnered __Separated __Dating

__Single __Divorced __Engaged

__Cohabiting __Widowed __Other

Information on those living in your household:

Name	Age	Sex	Relationship to you
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Significant others outside of the household:_____

_____

How do you feel about your current living situation?

Past and Present Marriage(s) or significant relationships (names, length of time together, nature of the relationship):

_____

_____

_____

_____

Do you have children who are not currently in the household? If so, please list names, ages, and how often you have contact with them: _____

_____

_____

How would you describe the status and quality of current relationships (including friendships)?

MEDICAL/TREATMENT INFORMATION

Please list significant current medical conditions (asthma, allergies, heart disease, thyroid disease, etc.):

Please list significant past medical conditions:

Have you ever been abused physically, sexually, or emotionally? If so, please explain:

Have you ever been hospitalized (when/ for what reason)?

Do you have previous counseling experience? (Dates/ with whom/ what was positive or negative):

Do you use/abuse any substances? (Includes alcohol and cigarettes) If so, please explain:

Do you have a history of using or abusing any substances? If so, please explain:

Please list current medications and/or supplements (include prescriptions, over-the-counter medication, and vitamins/supplements):

What do you do for exercise? How often do you exercise?

Information about sleep:
How many hours in a 24-hour period do you sleep?

How is the quality of that sleep (is it interrupted, do you feel rested afterwards, etc.)?

Family of origin: Please describe your mother, father, and siblings. Include their ages if alive (date and cause of death if deceased), places of residence, and careers. How would you characterize the relationships between your parents, between yourself and your parents, and between yourself and your siblings? Did you have a close relationship with any other relatives? Is there a history of mental illness, physical illness, suicide, pregnancy loss, substance abuse, physical / emotional / sexual abuse, etc. in your family of origin?

Is there anything else you think I should know?