



Te Anna Brown, MA, LPC

Embrace Counseling, LLC | 14485 E Evans Ave, Aurora, CO 80014

TeAnna.EmbraceCC@gmail.com | #720-616-8733 | #720-513-5858 (Fax)

The purpose of this questionnaire is to get a more complete picture of your personal, family and marital background without having to use a great deal of valuable therapy time. Please answer the questions as accurately as possible and feel free to ask questions. All of this information is completely confidential.

General Information

Today's Date: _____

NAME (Client 1): _____ Age: _____ Date of Birth: _____

(if applicable)

NAME (Client 2): _____ Age: _____ Date of Birth: _____

ADDRESS(s): _____

(including city, state & zip code)

Parent name(s) if client is a minor _____

Home phone: _____ Cell Phone: _____

Children's Name (s), siblings: (if applicable)

NAME: _____ DOB/Age: _____ Phone Number: _____

NAME: _____ DOB/Age: _____ Phone Number: _____

NAME: _____ DOB/Age: _____ Phone Number: _____

NAME: _____ DOB/Age: _____ Phone Number: _____

Check box for ethnicity:

African American Asian Caucasian Latino Native American Bi/Multiethnic

Military:

Yes _____ No _____ Dates of Service? _____ Which Branch? _____

Permission to Contact

Email address (parent, if a minor) _____

Do I have permission to leave Voice Messages? Y [] / N []

Do I have permission to email Y [] / N []

Do I have permission to text message Y [] / N []

Do I have permission for Video Chat Y [] / N []

Employment Information (parent (s), if minor)

OCCUPATION (Client 1) : _____ PLACE OF WORK: _____

OCCUPATION (Client 2) : _____ PLACE OF WORK: _____

Income (Client 1):

[] No income [] below 15 k [] 15k-20 [] 20-30k [] 30k-40k [] 40-50k [] 50 and above

Income (Client 2):

[] No income [] below 15 k [] 15k-20 [] 20-30k [] 30k-40k [] 40-50k [] 50 and above

Name of School attending or attended: _____

GRADE or EDUCATIONAL LEVEL: _____

GRADE or EDUCATIONAL LEVEL: _____

WHO REFERRED YOU? _____

Any criminal convictions? Y [] N [] If yes, please briefly explain:

Counseling information

Check Type of Counseling: Individual [] Couple [] Family []

Who will be present in the counseling sessions? Please write each name

1. BRIEFLY DESCRIBE the reasons for counseling?

2. HAVE YOU RECEIVED COUNSELING BEFORE: YES _____ NO _____

IF YES, HOW DID YOU FEEL ABOUT THE OUTCOME?

CHECK ALL OF THE FOLLOWING AREAS THAT YOU WOULD LIKE SUPPORT WITH:

Marriage/partner	YES__ NO__	Family	YES__ NO__
Job/School	YES__ NO__	Health	YES__ NO__
Self-Identify	Yes__ NO__	Relationships	YES__ NO__
Finances	YES__ NO__	Legal	YES__ NO__
Friendships	YES__ NO__	Mood	YES__ NO__
Anxiety Level	YES__ NO__	Eating habits	YES__ NO__
Spirituality	YES__ NO__	Anger	YES__ NO__
Alcohol	YES__ NO__	Drug(s)	YES__ NO__
Sexual difficulties	YES__ NO__	Caffeine	YES__ NO__
Smoking	YES__ NO__		
Other _____			

Domestic Violence currently or in the past: YES__ NO__

IF YES to any of the above, feel free to provide more information:

Medical Information

Are you/clients on any medication: (Please check one) [] YES [] NO

IF YES, please list NAMES OF MEDICATION, DOSAGE AND FREQUENCY TAKEN:

2. What is the general condition of your/client's health? _____

Physician's Name and Phone Number: _____

3. Do you/client use Drugs or Alcohol? YES_____ NO_____

IF YES, please share the names, the amount used, how often and any reasons for their usage:

In case of emergency please contact, please include name and relationship:

NAME: _____ PHONE: _____

NAME: _____ PHONE: _____

To the best of my knowledge, I attest that all of the above information is true:

Signature: _____ Date: _____

Signature: _____ Date: _____