



Eddie Konold M.A., L.P.C., C.A.C. II
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(970) 846-4620

New Client Intake Form

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

(Last) (First) (Middle Initial)

Birth Date: ____/____/____ Age: _____ Gender: _____

Marital Status:

- Never Married Domestic Partnership Married Separated Divorced Widowed

Please list any children/age: _____

Address: _____
(Street and Number)

(City) (State) (Zip)

Home Phone: (_____) _____ May we leave a message? Yes No

Cell/Other Phone: (_____) _____ May we leave a message? Yes No

E-mail: _____ May we email you? Yes No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

- No
- Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?

- No
- Yes

Please list: _____

Have you ever been prescribed psychiatric medication?

- Yes
- No

Please list and provide dates: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in _____

4. Please list any difficulties you experience with your appetite or eating patterns

5. Are you currently experiencing overwhelming sadness, grief or depression?

No

Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?

No

Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?

No

Yes

If yes, please describe _____

8. Do you drink alcohol more than once a week?

No

Yes

9. How often do you engage recreational drug use?

Daily Weekly Monthly Infrequently Never

10. Are you currently in a romantic relationship?

No

Yes If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes / no	
Anxiety	yes / no	
Depression	yes / no	
Domestic Violence	yes / no	
Eating Disorders	yes / no	
Obsessive Compulsive Behavior	yes / no	
Schizophrenia	yes / no	
Suicide Attempts	yes / no	

ADDITIONAL INFORMATION:

1. Are you currently employed?

- No
- Yes

If yes, what is your current employment situation:

Do you enjoy your work? Is there anything stressful about your current work?

2. Do you consider yourself to be spiritual or religious?

- No
- Yes

If yes, describe your faith or belief: _____

3. What do you consider to be some of your strengths?

4. What do you consider to be some of your weakness?

5. What would you like to accomplish out of your time in therapy?

STATEMENT OF DISCLOSURE

Eddie Konold, M.A., L.P.C., CAC II

419 Oak St.

Steamboat Springs, CO 80477-0489

970-846-4620

My degrees and credentials are:

- M.A. in Counseling Psychology and Counselor Education (Couples and Family Counseling) from the University of Colorado at Denver
- B.A. in Sociology from Colorado College
- N.C.C. Nationally Certified Counselor
- Licensed Professional Counselor
- Certified Addictions Counselor II

1. The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed psychologists, licensed social workers, licensed professional counselors, licensed marriage and family therapists, licensed school psychologists practicing outside the school setting, unlicensed individuals who practice psychotherapy, and certified/licensed addiction counselors.

The agency within the Department that has responsibility specifically for licensed and unlicensed psychotherapists is the:

Department of Regulatory Agencies
Mental Health Section
1560 Broadway, Suite 1350
Denver, Colorado 80202
(303) 894-7800.

2. Client Rights and Important Information:

a. You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy (if I can determine it), and my fee structure. Please ask if you would like to receive this information.

b. You can seek a second opinion from another therapist or terminate therapy at any time.

c. In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the Department of Regulatory Agencies, Mental Health Section.

d. Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the therapist is a licensed marriage and family therapist, a licensed social worker, a licensed professional counselor, a licensed psychologist, an unlicensed psychotherapist, or certified/licensed addiction counselor. If the information is legally confidential, the therapist may not disclose the information without the client's consent, except as provided in the confidentiality of the Mental Health Statute (C.R.S. § 12-43-218) and

certain other legal exceptions. You should be aware that provisions concerning the disclosure of confidential communications do not apply to any delinquency or criminal proceedings, except as provided in C.R.S. § 13-90-107. I will identify any exceptions to you if any such situation arises while the therapeutic relationship exists or after we have terminated the therapeutic relationship.

3. If you have any questions or would like additional information, please feel free to ask.

I have read the preceding information and understand my rights as a client/patient.

Client/Patient Signature

Date

Eddie Konold

Date