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CLIENT INFORMATION

First Name _____ Initial _____ Last Name _____

Date of Birth _____ Age _____ Gender: _____

Address _____

City _____ State _____ Zip _____

Best phone numbers to reach you (please circle Home/Work/Cell and list number):

1. H/W/C _____ May I leave a message? Yes ___ No ___

2. H/W/C _____ May I leave a message? Yes ___ No ___

Email Address: _____ May I email you? Yes ___ No ___

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

Name of Emergency Contact: _____

Phone: _____ Relationship to Client: _____

Parent/Person Responsible for Payment (if other than yourself):

First Name _____ Initial _____ Last Name _____

Address _____

City _____ State _____ Zip _____

Best Phone Number to Reach this Person: H/W/C _____

Relationship to Client: _____

ABOUT YOU:

Relationship Status: Never Married Married Single In a Relationship
 Partnered Separated Divorced Widowed

Length of Current Relationship: _____

How would you rate your relationship satisfaction on a scale of 1 to 10? _____

If you have children, please list names and ages: _____

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 or that have past relevance:

Current Medications (name/dosage/reason): _____

Primary Care Physician: _____ Phone _____

Address: _____

City _____ State _____ Zip _____

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

No

Yes. Please Describe: _____

Previous Dates of Counseling: _____

Have you ever been prescribed psychiatric medication? Yes No

Past psychiatric medications (name/date): _____

Current psychiatric medications (name/date/dosage): _____

Psychiatrist: _____ Phone: _____

Family History of Mental Health Issues (please list issue/family member):

Are you currently employed? Yes No

Occupation: _____

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

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: _____

Do you exercise? Yes No How many times per week? _____

What types of exercise do you participate in? _____

Please list any difficulties you experience with your appetite or eating patterns: _____

Do you drink alcohol or engage in substance use? Yes No

Please Name/How Often: _____

Are you presently struggling with suicidal thoughts or plans? Yes No

If yes, please describe: _____

Have you had past suicidal thoughts/attempts/hospitalizations? Yes No

If yes, please describe/date attempts and hospitalizations: _____

What do you consider to be some of your strengths? _____

What are some interests or meaningful activities in which you engage? _____

Do you feel supported by others? (do you have a person or people to listen and understand?):

Yes No

Please describe: _____

Reason for Seeking Current Counseling: _____

What are your current goals for counseling/How would you like your life to be different?

How do you think counseling can benefit you? _____

Is there anything else you feel would be important for me to know or understand about you?

Thank you for sharing this information with me. It will be of great benefit in our work together!