Supplemental Information Form

Thank you for your help in providing a thorough personal history. Completing this form before your first session will allow us more time to talk about the things that are most important to you right from the start. This information will be treated with the same high level of confidentiality as any other information you share. Please feel free to discuss any questions you may have about confidentiality with me.

Name ______________________________ Date of birth __________ Marital Status __________

Occupation (or school) ______________________ Highest grade completed ________________

Current medications and dosages ____

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Please note any allergies (including allergies to medications) ______________________________

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Current illnesses, injuries, or disabilities ____

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Past significant illnesses, injuries, or disabilities ____

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Previous psychotherapy, counseling, or psychiatric hospitalization? _________________________
If yes, when, for what problems, and with whom? _______________________________________

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Please note any way that previous therapy was helpful ___________________________________

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Have any family members had significant emotional problems (anxiety, depression, etc.) or been under the care of a mental health professional? Please describe. ____________________________

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Have you or any family members had any previous association with anyone at the Colorado Family Center for therapy, evaluation, or other services. If yes, please explain. ____________________

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Do you smoke? ____ How much per day? ____ Are you pregnant? ___ Using contraceptives? ____
How often do you consume alcohol in a typical month? ___________________________________
How many alcoholic drinks do you typically consume at one time? _________________________
Please note the type and frequency of any recreational drug use, past or present (e.g., marijuana, mushrooms, LSD, cocaine, over-the-counter medications) ___________________________________

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