🗝 Keys to Freedom Counseling & Neurofeedback 🗝

Welcome to our Office

Please print the requested information as completely as possible.

Date:_____

Name: Last _____First _____MI_____

Address _____City _____ZIP _____

Date of birth_____ Sex: M F_____

Home#:_____ Message OK?_____

Work:#_____ Message OK?_____

Cell#:_____ Message OK?_____

Email address_____

Referred by:_____

Payment Type: Please circle: Cash/Check/Credit

Card Name/Number/CVV/Exp. Date

_____

Employer:_____

Social Security #_____

Physician_____address_____

Phone number_____

Church attending:_____

Circle all that apply

Marital status:	Single	Married	Divorced	Separated	Widowed	
Abuse in past:	Sexual	Physical	Emotional	Spiritual	Verbal	Other_____
Addictions:	Alcohol	Drugs	Porn	Gambling	Sex Food	Other_____
Medical:	Post-Abortion	Miscarriage	C-section	Surgeries	Broken Bones	Other_____

Circle all mental health conditions: Depression Anxiety ADHD Bipolar PTSD OCD Other

All medications currently taking:_____

Mental health medications taken in the past: _____

List Any previous counseling, psychiatric treatment, or residential/in-patient care you have received (use back of page if necessary)

Therapist:_____Location_____Dates:_____

Reason:_____

7610 N. Union Blvd. ❦ Suite 145 ❦ Colorado Springs, CO 80920

719-210-9330 ❦ keystofreedom@me.com

Current Marriage – If Applicable

Spouse: Wedding year:

List Children/Name/M/F/Age: (Use back of page for additional space.)

Child:_____M F Age:_____

Child:_____M F Age:_____

Previous Marriages and/or Relationships with Children - Circle Spouse or Partner for each
(Use back of page for additional space.)

Spouse/partner:

Relationship Start (year):_____ End (year):_____

Child:_____M F Age:_____

Child:_____M F Age:_____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name_____

Relationship to Client_____

Address_____

Phone #'s (w)_____(c)_____(h)_____

Circle the best answer.

1. In general, do you have difficulty making or keeping friends?...Y / N
2. Would you normally describe yourself as a loner?... Y / N
3. In general, do you trust other people?... Y / N
4. Do you normally lose your temper easily?... Y / N
5. Are you normally an impulsive sort of person?... Y / N
6. Are you normally a worrier?... Y / N
7. In general, do you depend on others a lot?... Y / N
8. In general, are you a perfectionist?... Y / N
9. What gives your life meaning and purpose?

_____

10. Do you consider yourself to be a spiritual or religious person?_____
11. What religious practices did your parents participate in? Your grandparents (both maternal & paternal)?

_____

_____

12.What part of your current spiritual practice(s) brings you peace?

_____

13.What part of your current life circumstances do you believe your religion or spirituality influences?

_____

14.How do you think God behaves?

_____

15.What do you think God thinks of you?

_____

Circle the best answer.

16. Do you make yourself sick because you feel uncomfortably full? **Y/N**

17. Do you worry you have lost control over how much you eat? **Y/N**

18. Have you recently lost more than 15 pounds in a three-month period? **Y / N**

19. Do you believe yourself to be fat when others say you are too thin? **Y / N**

20. Would you say that food dominates your life? **Y / N**

21. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been accomplished?

Never Rarely Sometimes Often Very Often

22. How often do you have difficulty getting things in order when you have to do a task that requires organization?

Never Rarely Sometimes Often Very Often

23. How often do you have problems remembering appointments or obligations?

Never Rarely Sometimes Often Very Often

24. How often are you fidgety, restless or feel the need to leave your chair during a meeting or class?

Never Rarely Sometimes Often Very Often

25. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?

Never Rarely Sometimes Often Very Often

26. How often do you feel compelled to do things, like you were driven by a motor?

Never Rarely Sometimes Often Very Often

Level of Distress

Indicate how distressed you are in by circling the appropriate number on the scale below

(1=Very Little Distress 6=High stress 10=overwhelmed)

1	2	3	4	5	6	7	8	9	10