Louis Carlino, MA, LPC
(303) 815-0898
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www.BodyPsychYoga.com

Date_____

Client Information	
Legal Name:	Preferred Name (if different):
Age:	Date of Birth:
Address: City: State/Zip:	
Email:	
Occupation:	
Educational Level:	
Emergency Contact: Relationship: Phone:	
Primary Phone: Home/Work/Cell (circle one) Best time to reach you: Okay to leave detailed message? □ Yes □No	Secondary Phone: Home/Work/Cell (circle one) Best time to reach you: Okay to leave detailed message? □ Yes □No
Medical Information	
MD: Phone: Psychiatrist: Phone: Medical Problems/Prescribed Medications:	

Personal Information (leave blank any items you do not feel comfortable answering)
Gender Identification: Ethnic/Cultural Identification: Sexual Orientation: Relationship Status: Religious/Spiritual Affiliation:
Current Living Situation:
Do you have children? If so, ages:
Background Information
Briefly describe your reason(s) for seeking therapy at this time:
What are your goals for therapy?
Briefly describe any major losses or traumas:
Have you been in therapy before? If so, please describe briefly:
Have you ever attempted suicide? If so, when?
Have you ever been hospitalized for mental health issues? If so, when?
Current use of alcohol/recreational drugs (please describe briefly)
Previous use of alcohol/recreational drugs:

Does your family have any history of mental illness, suicide, substance abuse, trauma, or abuse? If so, please describe briefly:
Any other comments: