NEW CLIENT INFORMATION
CORAM DEO COUNSELING & CONSULTING, PLLC
TERRY L. LAMBRIGHT, PhD, LPC
3225 Templeton Gap Road, Suite 202
Colorado Springs, CO 80907
719-550-1477
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Your complete name: ______________________________

Address: ______________________________

City: ______________ State: ___________ Zip/Postal Code: ___________

Home phone: ______________ Daytime number: ______________

Age: _____ Birthdate: ______ Birthplace: ______________

Last year of school completed: 9 10 11 12 GED College: 1 2 3 4

Current Occupation: ______________________________

Person to alert in the event of medical emergency: ______________________

Relationship to you: ______________ Phone: ______________

Family Doctor: ______________ Phone: ______________

Relationship status (circle one): Single Married Partnered Separated Divorced Widowed

Spouse/partner's 1st name: ______________ Age: _____ Yrs. in relationship: _____

Children (gender, age): ______________________________

Do you have a religious preference? ☐ Yes ☐ No Attend Church? ☐ Yes ☐ No

Church name: ______________ Pastor: ______________

Importance of church to you: Not at all Somewhat Very Extremely

IMPACT OF LIFE CIRCUMSTANCES

Circle any PROBLEMS that concern you now:

Relationship(s): Spouse Children Parents In-laws Co-workers Friends Teachers

Alcohol Binge eating Anxiety Anger Codependency Communication Career Excessive dieting or exercise Loneliness Fear Prescription drugs Procrastination Shopping Feelings about church or God Stress Gender identity Sex Mood swings Pornography Self-esteem Depression Street drugs

Other problems:______________________________

Circle any VICTIMIZATIONS you have experienced:

Child abuse: Physical Emotional Sexual Incest

Spouse abuse: Physical Emotional Sexual

Abandonment Rape Robbery Assault Suicide attempt Auto or industrial accident Major illness Surgery Physical disability

Other victimizations: ______________________________

Circle any LOSSES that you have experienced:

Abortion   Bankruptcy   Broken engagement   Career or job loss   Separation   Divorce   Suicide

Homelessness   Infertility   Miscarriage   Death of someone. Who? ____________________

Other losses: ____

CURRENT INTENSE EMOTIONAL DISTRESSES

Suicidal thoughts, plans, attempts: ______________________________

Homicidal thoughts, plans, attempts: ______________________________

Desire to cause pain to self or others: ______________________________

In fear for your life or personal safety: ______________________________

Too depressed to care for self or family: ______________________________

Please describe any significant current or past medical problems:

____

____

Please list any medications you currently take. Include prescription and over-the-counter medications and the dosage of each.

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____

Have you had previous psychological care or counseling? ☐ **Yes** ☐ **No**

If yes, please give the name of the clinicians, the months you saw them, and the nature of the difficulty.

____

____

Have you ever been hospitalized for a psychological difficulty? ☐ **Yes** ☐ **No**

If yes, please give the dates and the nature of the difficulty at the time:

____

____

What is the nature of the concern that you wish to address in therapy? What are your goals?

____

____

____

In signing below, I affirm that the information given on this form is true and complete.

______________________________	__________	______________________
Client, Custodial Parent, or Guardian	Date	Minor