Caitlin Kozicki, MA, NCC, LPC, CAC III, CEAP
7220 W. Jefferson Ave., Ste 218
Lakewood, CO 80235
Confidential voicemail/Direct line: 303-957-6504
Ckozicki98@gmail.com

The information you provide in this intake form may be confidential; however, certain otherwise confidential information may be shared as required by law. You are not required to supply the information contained in this Intake Form. Please provide as much information as possible.

Any request or authorization in this form to contact a Third Party, such as a medical doctor, will require a separate Authorization for Release of Information.

Date: ___/___/_____

Legal Name: _____

Name you preferred to be called: _____

Date of birth: ___/___/_____ Age: _____

Pregnant: □ Yes □ No □ N/A Child under the age of 1: □ Yes □ No Dependents: □ Yes □ No

If yes: Name and Age: _____ Number of persons supported by income: _____

_____

_____

Highest level of education: _____

Demographics

Gender	Ethnicity		Marital Status	
☐ Female	☐ Asian	☐ Native American	☐ Divorced	☐ Remarried
☐ Male	☐ Black	☐ Pacific Islander	☐ Domestic Partner	☐ Separated
☐ _____	☐ Hispanic/Latino	☐ White	☐ Married	☐ Widowed
	☐ Multi-Ethnicity	☐ Other: _____	☐ Never Married	

Physical Address:

_____

Number Street Apt #

_____

City State Zip code

May Caitlin Kozicki contact you at this address: ☐ YES ☐ NO

Home phone: (_____)_____-_____ message okay: □ Yes □ No

Cell phone: (_____)_____-_____ message okay: □ Yes □ No

Work phone: (_____)_____-_____ message okay: □ Yes □ No

May Caitlin Kozicki contact you at all the above telephone numbers provided: ☐ YES ☐ NO

E-mail: _____@_____

Do you share this email address with anyone else? If so please list who else shares the email address:
_____

May Caitlin Kozicki contact you at the above email address: ☐ YES ☐ NO

****Please be aware there is a risk that an unintended third-party may access information shared by electronic transmissions such as email and cell phone. By allowing Caitlin Kozicki to contact you by email you are consenting to receive electronic communications and understand the risks involved. Caitlin Kozicki cannot guarantee that confidential information shared using electronic communications will remain confidential.**

What is your preferred method of communication:

☐Telephone (H) ☐ Cell Phone, including texts ☐ Telephone (W) ☐ Email
Emergency contact: _____
Name Relationship

Emergency contact phone number(s): (_____)_____-_____ □ Home □ Cell □ _____
or
(_____)_____-_____ □ Home □ Cell □ _____

Address:

_____
Number Street Apt #

_____
City State Zip code

In the event of an emergency, may I contact your emergency contact?
□ Yes _____ ___/___/_____ (initial & date)
□ No

Billing information:

□ EAP: _____

Any disabilities:
□ Developmental disability □ Blind/vision loss □ Traumatic Brain Injury □ Deaf/hearing loss
□ Learning disability □ None

Any history of trauma? □ Yes □ No

Employment:

□ Full-Time (35+ hours/week) □ Part-Time (<35 hours/week) □ Unemployed □ Homemaker □ Student □ Retired □ Disabled □ Volunteer

Employer: _____ Current position at work: _____

How long have you been employed by your current employer? _____

Typical work hours: _____ Typical work days: _____

Any current workplace concerns? □ Yes □ No
If yes, explain:

_____

_____

In the past month, how many days were you unable to work because of your physical or mental health: _____

In the past month, how many were you able to work but had to cut back on how much you got done because of your physical or mental health: _____

What led you to access EAP services? Presenting concern that you would like to address?

_____

_____

_____

_____

How often do you have a drink containing alcohol? _____

If yes, what type of alcohol? _____

Date/age of first use of alcohol _____ Date/age of last use of alcohol _____

How many drinks containing alcohol do you have on a typical day when you are drinking? _____
***One drink = 12 oz beer, 5 oz wine, 1 ½ oz liquor**

How often do you have four or more (women and men 65 and older)/ five or more (men) drinks on one occasion? _____

Do you use tobacco currently? □ Yes □ No

If yes, what type of tobacco? _____ Frequency of use? _____

Have you used tobacco in the past? □ Yes □ No

Do you use caffeine? _____ Frequency of use? _____

Date/age of first use of marijuana _____ Date/age of last use of marijuana _____

In the past year, how many times have you used marijuana? _____

In the past, have you used/experimented with an illegal drug or prescription drug for non-medical reasons?
□ Yes □ No If yes: □ Illegal drug _____ or □ prescription drug _____

If yes, within the last year? □ Yes □ No

Have you taken any prescription drugs not prescribed to you or for a purpose for which they were not prescribed?
□ Currently □ In the past year □ Prior to a year ago □ Never

Date/age of first use of cocaine _____ Date/age of last use of cocaine _____

Date/age of first use of Methamphetamine _____ Date/age of last use of Methamphetamine _____

Over the past 2 weeks, how often have you been bothered by the following problems?
Little interest or pleasure in doing things - □ Not at all □ Several Days □ More than half the days □ Nearly every day
Feeling down, depressed, or hopeless - □ Not at all □ Several Days □ More than half the days □ Nearly every day

Over the past 2 weeks, how often have you been bothered by the following problems?
Feeling nervous, anxious, or on edge - □ Not at all □ Several Days □ Over half the days □ Nearly every day
Not being able to stop or control worry - □ Not at all □ Several Days □ Over half the days □ Nearly every day

Have you had any thoughts about harming yourself?
□ Current/recent thoughts □ Past thoughts – Date: _____ □ Never

Have you had any thoughts about harming someone else?
□ Current/recent thoughts □ Past thoughts – Date: _____ □ Never

Past and current mental health diagnosis, treatment, & medication (Dates, type, duration, location):

□ N/A

_____

_____

Past and current substance use diagnosis, treatment, & medication (Dates, type, duration, location):

□ N/A

_____

_____

Legal Information:

Have you ever been arrested for any reason? ☐ Yes ☐ No
Driving offense? ☐ Yes ☐ No
DUI ☐ Yes ☐ No
DUI-D ☐ Yes ☐ No
DWAI ☐ Yes ☐ No
Speeding ☐ Yes ☐ No

If yes, what is your current legal involvement (e.g., awaiting charges/trial, drug court, probation, litigation, etc.)? Please describe:

_____

_____

Physical health:

Primary care physician: _____ Specialist/Other Physician: _____

Phone number: _____ Phone number: _____

Date of last visit: _____ Date of last physical: _____

Acupuncturist: ☐ Yes ☐ No Name: _____

Chiropractor: ☐ Yes ☐ No Name: _____

Massage therapist: ☐ Yes ☐ No Name: _____

Current illnesses or medical conditions, treatments, and medications (including over-the-counter drugs, vitamins, herbs, and other supplements):

_____

_____

_____

Significant past illnesses, medical conditions, treatments, hospitalizations, including dates:

□ N/A

_____

_____

_____

Describe any changes related to your mental health during pregnancy or postpartum:

□ N/A

_____

_____

_____

Any medical, mental health or substance use issues in your family history? Include relation to the client:

_____

_____

_____

Past and current self-care practices:

_____

_____

_____

Allergies: ☐ Food ☐ Environmental ☐ Medications

Nutrition:

Current weight: _____ Current Height: _____ Recent weight changes: ☐ Gained ☐ Lost Lbs: _____

Number of snacks per day: _____ Balanced diet: ☐ Yes ☐ No

Typical diet (breakfast, lunch, dinner):

_____

_____

Exercise:
Times per week: _____ Average time of workout: _____
Type:

_____

_____

Sleep:
Number of hours per night: _____ Time to onset of sleep: _____ minutes

Ability to Concentrate:	Sleep Interruptions:		Energy Level:	Feels Rested:
☐ Normal ☐ Difficult	☐ Snoring ☐ Complaints from Sleep Partner ☐ Difficulty Turning off "Thoughts" ☐ Gasping for Air ☐ Night Time Urination *Frequency:* _____ ☐ Baby/young child	☐ Nightmares ☐ Sleep Apnea ☐ Teeth Grinding ☐ Waking During the Night ☐ Other: _____	☐ High ☐ Average ☐ Low	☐ Yes ☐ No

Remarks:

_____

_____

Reasons you left previous counseling or treatment?

_____

_____

Who do you currently live with:
☐ Alone ☐ Mother ☐ Father ☐ Sibling(s) ☐ Relative(s), kin ☐ Guardian ☐ Spouse ☐ Partner/Significant other
☐ Child(ren) ☐ Unrelated Person(s)

Describe your current living and/or support system:

_____

_____

What would you like to gain from your appointments?

_____

_____

_____

Checklist of Concerns:

Please mark all of the areas of concern below that apply to you. You may add a note or details in the space next to the concerns checked.

CONCERN	NOTES	NOW	IN THE PAST
Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals			
Aggression, violence			
Alcohol use			
Anger, hostility, arguing, irritability			
Anxiety, nervousness			
Attention, concentration, distractibility			
Career concerns, goals, and choices			
Childhood issues (your own childhood)			
Codependence			
Confusion			
Compulsions			
Custody of children			
Decision-making, indecision, mixed feelings, putting off decisions			
Delusions (false ideas)			
Dependence			
Depression, low mood, sadness, crying			
Divorce, separation			
Drug use—prescription medications, over-the-counter medications, street drugs			
Eating problems—overeating, undereating, appetite, vomiting, (see also "Weight and diet issues")			
Emptiness			
Failure			
Fatigue, tiredness, low energy			
Fears, phobias			
Financial or money troubles, debt, impulsive spending, low income			
Friendships			
Gambling			
Grieving, mourning, deaths, losses, divorce			

CONCERN	NOTES	NOW	IN THE PAST
Guilt/Shame			
Headaches, other kinds of pains			
Health, illness, medical concerns, physical problems			
Housework/chores—quality, schedules, sharing duties			
Inferiority feelings			
Interpersonal conflicts			
Impulsiveness, loss of control, outbursts			
Irresponsibility			
Judgment problems, risk taking			
Legal matters, charges, suits			
Loneliness			
Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments			
Memory problems			
Menstrual problems, PMS, menopause			
Mood swings			
Motivation, laziness			
Nervousness, tension			
Obsessions, compulsions (thoughts or actions that repeat themselves)			
Oversensitivity to rejection			
Pain, chronic			
Panic or anxiety attacks			
Parenting, child management, single parenthood			
Perfectionism			
Pessimism			
Procrastination, work inhibitions, laziness			
Relationship problems (with friends, with relatives, or at work)			
School problems (see also “Career concerns ...”)			
Self-centeredness			
Self-esteem			
Self-neglect, poor self-care			
Sexual issues, dysfunctions, conflicts, desire differences, other (see also “Abuse”)			

CONCERN	NOTES	NOW	IN THE PAST
Shyness, oversensitivity to criticism			
Sleep problems—too much, too little, insomnia, nightmares			
Smoking and tobacco use			
Spiritual, religious, moral, ethical issues			
Stress, relaxation, stress management, stress disorders, tension			
Suspiciousness, distrust			
Temper problems, self-control, low frustration tolerance			
Thought disorganization and confusion			
Threats, violence			
Withdrawal, isolating			
Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition			

❑ Other concerns or issues:

_____

_____

_____

Client Affirmation:

By signing this Intake Form, I certify that all the information is true and accurate to the best of my knowledge.

Client signature: _____ Date: _____

Client printed name: _____