Catherine Warnock, MA, LPC, NCC
12835 E. Arapahoe Rd. Ste 2-440, Centennial, CO 80112
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Registration Form

Name: ____ Date:___________________

Address: ____

Mobile Phone #_____________________________ Alternative Phone #___________________________

Can I leave a message? ❑Yes ❑No Email: ____

Can I send you a text? ❑Yes ❑No

How did you find or hear about Mariposa Counseling Center? _____________________________________

____

Date of Birth: ______________________ Age: ________ Gender: ________________

Emergency Contact Name: ____

Relationship: _________________________________Phone #: ______________________

Employer: __________________________________ Occupation: _________________________________

Nationality or Ethnicity: ____________________________ Sexual Orientation: ______________________

Marital Status: ___Single ___Married___ (years) ___Divorced ___(years)

___Living Together___ (years) ___Separated___ (years) ___Widowed___ (years)

Name of Partner/Spouse: ____

Spiritual/Religious Affiliations: ____

Primary Care Physician: _____________________________________ PCP phone #: __________________

Have you been in therapy before? ❑Yes ❑No If yes, who and when? __________________________

____

Do you have a psychiatrist? ❑Yes ❑No

If yes, who?____ phone #: ______________________

Medications (prescriptions, vitamins, supplements, etc.)

Drug	Dose	Frequency	For Treatment of
1.			
2.			
3.			
4.			
5.			
6.			

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Please describe the issue that brought you in today: ____

____

____

Any history of abuse (physical, emotional, or sexual): ____

____

____

How many alcoholic drinks do you have…. per day? ________ per week? _______ per month? ________

Please list any other drugs you take for recreational purpose and the frequency of use: ______________

____

List your history of substance use, abuse and/or treatment: ______________________________________

____

____

Is there a history of substance use or abuse in your family? ❑Yes ❑No

If so, please provide some details ____

____

Previous psychiatric hospitalizations? ____

If so, when and where? ____

____

Previous psychiatric medications? ____

Any custody issues or other legal issues: ____

____

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Current Symptoms Checklist: (check mark the rate the intensity of symptoms currently present)

None= This symptom is not present at this time.
Mild= Impacts quality of life, but no significant impairment of day-to-day functioning.
Moderate (Mod)= Significant impact on quality of life and/or day-to-day functioning
Severe= Profound impact on quality of life and/or day-to-day functioning.

Symptom	None	Mild	Mod	Severe	Symptom	None	Mild	Mod	Severe
Depressed mood					Hallucinations: visual				
Stress					Hallucinations: audio				
Change in sleeping habits					Dissociative states				
Muscle tension					Change in libido				
Physical pain					Change in eating habits				
Fatigue/low energy					Significant weight gain/loss				
Poor concentration					Anorexia				
Worthlessness					Binge eating				
Hopelessness					Purging/vomiting				
Mood swings					Laxative/diuretic use				
Emotionality/labile					Substance abuse				
Elevated mood					Somatic complaints				
Agitation					Sexual dysfunction				
Anger/Irritability					Self-mutilation				
Social isolation					Guilt				
Conduct problems					Grief				
Oppositional behavior					Relationship problems				
Aggressive behaviors					Domestic Violence **(V)** *				
Hyperactivity					Domestic Violence **(P)***				
Generalized anxiety					Emotional trauma **(V)***				
Panic attacks					Emotional trauma **(P)***				
Phobias					Physical trauma **(V)***				
Obsessions					Physical trauma **(P)***				
Compulsions					Sexual trauma **(V)***				
Delusions					Sexual trauma **(P)***				
Sadness					Suicidal Thoughts				
Feeling fearful					Acting violently				
Memory problems					Thoughts of hurting others				
Nightmares/Night Terrors					Flashbacks				
Lack of enjoyment in usual activities					Trouble performing at work/school				

*** V=victim P=perpetrator**

Please provide any additional information regarding the above symptoms here: ____________________

____

____

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Please provide a list of all medical (mental and physical) conditions, diseases, or disorders that you have experienced. Please also note which conditions are current.

____

____

____

____

____

Please provide any additional information that you think is relevant to our working together:_________

____

____

____

____

____