University of Colorado Denver
Student and Community Counseling Center

Client Information Form

FOR OFFICE USE ONLY
Client can be seen by:
o Student
o Intern/Licensed Clinician
o Licensed Clinician Only

Date: _____ **Time:** _____ ☐ AM ☐ PM

UCD Student: ☐ Yes ☐ No If yes, please indicate: ☐ Undergraduate ☐ Graduate
Student ID Number: _____ **Are you a veteran?** YES/NO

International Student? Yes No
Health Insurance? Yes No
Name: _____

Counseling Services you are seeking: ☐☐ Individual Adult ☐☐ Individual Child ☐☐ Couple ☐Family ☐ Group

Client Name: _____
Parent or Guardian Name (if client is under 16): _____
Address: _____
City: _____ State: _____ Zip Code: _____
Please check the box if it is NOT ok to send mail to this address. ☐
Date of Birth: _____ Age: _____ Gender: _____
Ethnicity: _____ Employment/School: _____

Telephone Number(s): (please check the best number to call)
Best time(s) to call: _____ **Okay to leave detailed message?**
☐ Home: _____ ☐ Yes ☐ No
☐ Cell/Other: _____ ☐ Yes ☐ No

How urgent is your need for counseling? (Scale of 1-10, 1=low, 10=high) _____

Available times for appointments: (please check all available days)
☐ Monday Times: _____
☐ Tuesday Times: _____
☐ Wednesday Times: _____
☐ Thursday Times: _____
☐ Friday Times: _____

If you are seeking couple or family therapy, please complete the following information

Client Name (Significant Other): _____
Address: _____
City: _____ State: _____ Zip Code: _____
Date of Birth: _____ Age: _____ Gender: _____
Ethnicity: _____ Employment/School: _____

Telephone Number(s): (Please check the best number to call)
Best time(s) to call: _____ ***Okay to leave detailed message?***
☐ Home: _____ ☐ Yes ☐ No
☐ Cell/Other: _____ ☐ Yes ☐ No

Additional Family Members:
Client Name: _____
Date of Birth: _____ Age: _____ Gender: _____
Ethnicity: _____ Employment/School: _____

Client Name: _____
Date of Birth: _____ Age: _____ Gender: _____
Ethnicity: _____ Employment/School: _____