# CRAIG DAVID LOUNSBROUGH, M.DIV., LPC

19284 Cottonwood Drive, Suite 202
Parker, Colorado 80138
(303) 593-0575


Welcome to my practice. I appreciate the fact that you have selected me for your counseling needs. I will strive to provide you with the best care possible. To help me more effectively meet your needs, please fill out this form completely in ink. If you have any questions or need assistance, please feel free to ask me as our first session begins.

Date _____

Patient's Name _____ SS# _____ DOB _____

Gender: Male _____ Female _____ Marital Status _____

Street Address _____

City, State and Zip _____

Home Phone Number _____ Referred by _____

Occupation _____

Employer _____ Phone Number _____

Employer's Address _____

City, State and Zip _____

Church _____ Member _____ Attender _____

Denomination _____ Pastor _____

Do you wish to sign a release of information allowing me to include your Pastor/Priest as a part of your treatment team? If you check the "Yes" box, please fill out the attached "Release of Information" form so that I can contact them. Yes _____ No _____ N/A _____

**Please take time to complete the following *if the responsible party is someone other than the person listed above*. If you plan to submit your claims for insurance reimbursement, the following information must be complete about the insured.**

Name _____ SS# _____ DOB _____

Gender: Male _____ Female _____ Marital Status _____

Occupation _____

Employer _____ Phone Number _____

Employer's Address _____

**PLEASE COMPLETE BOTH SIDES OF THE PATIENT DATA SHEET**

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City, State and Zip _____

In Case of Emergency Contact _____

Their Home Phone # _____ Work # _____

Name of Your Physician _____ Phone # _____

Do you wish to sign a release of information allowing me to include your Physician as a part of your treatment team? If you check the "Yes" box, please fill out the attached "Release of Information" form so that I can contact them. Yes _____ No _____ N/A _____

Briefly explain your reason for seeking therapy: _____

_____

_____

What do you hope to accomplish from therapy: _____

_____

_____

Please list all previous therapist(s) and counseling experience(s): _____

_____

Have you formally terminated therapy with your previous therapist? *Yes _____ No _____ N/A ____

*If you have terminated with your previous therapist, do you wish to sign a "Release of Information" form so that I can receive copies of your records? Yes _____ No _____ N/A ____

If you would like to be added to our email list to receive helpful information and tips on a wide variety of mental health issues, please print your email address here: _____

_____ _____
Signature Date

_____ _____
Signature of Partner (If seeking conjoint/marital therapy) Date

**PLEASE COMPLETE BOTH SIDES OF THE PATIENT DATA SHEET**