DENVER DIABETES COUNSELING

Jenna Eisenberg, LMFT
5650 Greenwood Plaza Blvd, Ste 225K
Greenwood Village, CO 80111
720-420-6541
www.denverdiabetescounseling.com
Colorado License Number: MFT 898
National Provider Identifier (NPI): 1417113341

Intake Information

Name: Date:

Street: City: State:

Zip: Home Phone: Cell Phone:

Employer: Work Phone:

Work Address: Occupation:

Sex: *Male* *Female* Ethnicity: Date of Birth: Age:

Marital status (circle all that apply): *Single* *Engaged* *Living together* *Married* *Separated* *Divorced* *Widowed*

Name of Spouse: Spouse's Employer:

E-mail: Referred by:

Names of Persons Living in Your Home:	Age	Gender	Living w/ you?	Comments:
		M F	*Yes No*	
		M F	*Yes No*	
		M F	*Yes No*	
		M F	*Yes No*	
		M F	*Yes No*	

Briefly state your reason for seeking counseling at this time:

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Please check the response that best answers the three next questions	Not at All	Mildly	Moderately	Highly
How serious do you consider your present concern(s)?				
How motivated are you to resolve your concern(s)?				
How optimistic are you that your concern(s) can be resolved?				

Have you/family member ever been seen by a mental health professional before?

Yes *No*

If yes, please indicate who (address, phone), when and why:

Would you consent for Jenna Eisenberg, LMFT and Denver Diabetes Counseling to contact him/her on your behalf? *Yes* *No*

Under what conditions do your problems get:

Worse –

Better –

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Which category best describes you or your family member's diet?

- ❑ *Very Healthy* (Lots of fresh fruits/vegetables/whole grains, and few sweets/fatty foods.)
- ❑ Between *Moderately Healthy* & *Very Healthy*
- ❑ *Moderately Healthy* (Some fresh fruits/vegetables/whole grains, and some sweets/fatty foods.)
- ❑ Between *Unhealthy* & *Moderately Healthy*
- ❑ *Unhealthy* (Few fresh fruits/vegetables/whole grains, and lots of sweets/fatty foods.)

Do you/family member regularly practice relaxation techniques (e.g. meditation, yoga, Tai Chi)? *Yes* *No*

If yes, what and how often?_____

How often do you get 20 minutes or more of exercise? _____

How much do you usually smoke? _____

How much alcohol do you usually drink? _____

Do you use "recreational" drugs? *Yes* *No* If yes, what and how often? _____

_____

Do you take vitamins and/or herbal remedies? *Yes* *No*

If yes, what and how often? _____

_____

Who is your/family member's Primary Physician:

Phone/Address:

Would you consent for Jenna Eisenberg, LMFT and Denver Diabetes Counseling to contact him/her on your behalf? *Yes* *No*

Please list any troublesome or significant medical conditions you may have:

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Please list you or your family member's latest A1C levels and other relevant Diabetes information:

Please list your current medications (Prescription & Non-Prescription):

Drug	Dose	Frequency	When Started	For what symptom(s)	Prescribing Doctor

Who should be notified in case of emergency?

Name: Relationship:

Home Phone: Work Phone:

Please provide any other pertinent information:

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Name **Date**

Symptom Frequency Scales

How often have you or your family member experienced the following symptoms over the last two weeks?

Depression	***Not at all***					***Sometimes***					***All the time***	✓ **Diabetes Related**
Feelings of sadness	0	1	2	3	4	5	6	7	8	9	10	
Difficulty falling asleep and/or staying asleep	0	1	2	3	4	5	6	7	8	9	10	
Desire to spend a lot of time sleeping	0	1	2	3	4	5	6	7	8	9	10	
Fatigue or loss of energy	0	1	2	3	4	5	6	7	8	9	10	
No interest in formerly pleasant activities	0	1	2	3	4	5	6	7	8	9	10	
Feelings of worthlessness	0	1	2	3	4	5	6	7	8	9	10	
Feelings of hopelessness	0	1	2	3	4	5	6	7	8	9	10	
Feelings of excessive and/or inappropriate guilt	0	1	2	3	4	5	6	7	8	9	10	
Thoughts of being punished	0	1	2	3	4	5	6	7	8	9	10	
Impaired ability to concentrate	0	1	2	3	4	5	6	7	8	9	10	
Indecisiveness	0	1	2	3	4	5	6	7	8	9	10	
Excessive appetite OR poor appetite	0	1	2	3	4	5	6	7	8	9	10	
Feelings of restlessness	0	1	2	3	4	5	6	7	8	9	10	
Sense of moving slowly	0	1	2	3	4	5	6	7	8	9	10	
Thoughts of death	0	1	2	3	4	5	6	7	8	9	10	
Thoughts of suicide	0	1	2	3	4	5	6	7	8	9	10	
Difficulty maintaining Diabetes	0	1	2	3	4	5	6	7	8	9	10	
Not maintaining Diabetes	0	1	2	3	4	5	6	7	8	9	10	
Unplanned weight gain OR weight loss	NO YES If yes, how much?											

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Name **Date**

Symptom Frequency Scales

How often have you or your family member experienced the following symptoms over the last two weeks?

Anxiety	***Not at all***					***Sometimes***					***All the time***	**✓ Diabetes Related**
Inability to relax	0	1	2	3	4	5	6	7	8	9	10	
Nervousness	0	1	2	3	4	5	6	7	8	9	10	
Numbness or tingling	0	1	2	3	4	5	6	7	8	9	10	
Heart pounding or racing	0	1	2	3	4	5	6	7	8	9	10	
Indigestion and/or discomfort in abdomen	0	1	2	3	4	5	6	7	8	9	10	
Feelings of choking	0	1	2	3	4	5	6	7	8	9	10	
Shaky	0	1	2	3	4	5	6	7	8	9	10	
Scared	0	1	2	3	4	5	6	7	8	9	10	
Difficulty breathing	0	1	2	3	4	5	6	7	8	9	10	
Racing thoughts	0	1	2	3	4	5	6	7	8	9	10	
Sweating (not due to heat)	0	1	2	3	4	5	6	7	8	9	10	
Dizziness or lightheaded	0	1	2	3	4	5	6	7	8	9	10	
Excessive worry about A1C levels	0	1	2	3	4	5	6	7	8	9	10	
Excessive worry about Blood Sugars	0	1	2	3	4	5	6	7	8	9	10	
Excessive worry/fear about Complications	0	1	2	3	4	5	6	7	8	9	10	
Fear of the worst happening	0	1	2	3	4	5	6	7	8	9	10	
Fear of losing control	0	1	2	3	4	5	6	7	8	9	10	
Fear of dying	0	1	2	3	4	5	6	7	8	9	10	