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CLIENT INFORMATION FORM

Your Name: ____ **Age:** __________
Last First Middle

Today's Date: ______________ **Date of Birth:** ______________ **SSN:** __________

Home Street Address: ____

City: ______________________ **State:** ______ **Zip:** ______________

Name of Employer: ____

Address of Employer: ____

City: ______________________ **State:** ______ **Zip:** ______________

Home Phone: ______________________ **Work Phone:** ______________________

Cell Phone: ______________________ **Email:** ______________________

Calls will be discreet, but please indicate any restrictions:______________________

____

Referred by: ____

Person(s) to notify in case of any emergency: ______________________
name phone#

Please briefly describe your current concerns: ______________________

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____

What are your goals for therapy? ______________________

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** The following information on this form will help guide your treatment. Please try to fill out as much as you are comfortable disclosing.*

MEDICAL/PHYSICAL HEALTH HISTORY

Please explain any current medical problems, symptoms, or illnesses: ___________________________

____

____

____

Current Medications:

Name	Dosage	Purpose	Name of Prescribing Physician

Previous medical hospitalizations, significant illnesses or injuries (please include approximate dates):

____

____

____

Height: ________________ Weight:_______________

Briefly describe your nutritional and exercise/physical activity patterns:

____

____

____

How many hours of sleep do you get per night (on average)? _____________

Describe any persistent problems with sleep (falling asleep, staying asleep, waking too early, etc.): ______

____

____

Do you smoke or use tobacco? YES NO If YES, how much per day?___________________________

Do you consume caffeine? YES NO If YES, how much per day?___________________________

Do you drink alcohol? YES NO If YES, how much per day?___________________________

Do you use any non-prescription, recreational or club drugs? YES NO

If YES, what kinds and how often?____

Have you experimented with or regularly used any recreational substances in the past? YES NO

If YES, what kinds and how often? ____

Have any of your friends or family members voiced concern about your substance use? YES NO

Have you ever been in trouble or in risky situations due to your substance use? YES NO

If YES, please describe:

____

Have you ever had problems with addiction to prescription medications/painkillers or have you routinely needed to take more than prescribed to manage pain? YES NO

If YES, please describe:

____

Have you ever met with a psychiatrist, psychologist, or other mental health professional? YES NO

If YES, please list approximate dates and reasons:

____

____

____

Previous inpatient psychiatric hospitalizations (please include approximate dates and reasons):

____

____

____

FAMILY

How would you describe your relationship with your parents? _______________________________

____

____

Are your parents married/together? YES NO

If NO, how old were you when they divorced or when the relationship ended? ________________

What effect did this have on you? ____

Are either of your parents deceased?____

Mother's Name: ________________ How would you describe your relationship with your mother?

____

____

Father's Name: __________________ How would you describe your relationship with your father?

____

____

Name any other significant caregivers you had: ___________________________________

How many siblings do you have? __________ Where are you in the birth order? __________________

Names and Ages of Sisters:____

Names and Ages of Brothers:____

How would you describe your relationship(s) with your sibling(s)?________________________________

____

____

RELATIONSHIPS, SOCIAL SUPPORT & SELF-CARE

I identify my gender as: _______________ Preferred pronoun(s): ___________________________

Sexual Identity: Heterosexual___ Lesbian___ Gay___ Bisexual___ Transgender___ Questioning__

Other ____

Married/Long-term Partnered? YES NO For how long? _________________________

Previously Married/Life-Partnered? YES NO For how long? _________________________

Currently in a relationship? YES NO For how long? _________________________

Relationship Satisfaction: (Poor) 1 2 3 4 5 6 7 (Excellent)

Name of Spouse/Partner/Girlfriend/Boyfriend: ____

Do you have children? YES NO If YES, please list their names and ages: _____________________

____

Describe any concerns about your children: ____

____

List the names and ages of any others living in your household:

____

____

Please briefly describe any history of abuse (physical, sexual or emotional), neglect and/or trauma:

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____

____

____

Current level of satisfaction with your social support/friends: (Poor) 1 2 3 4 5 6 7 (Excellent)

Please name any significant friends or close confidants: ____

Please briefly describe how you cope with stress and take care of yourself:

____

____

____

Do you have a cultural, national or ethnic heritage that is important to you? YES NO

If YES, please describe:

____

EARLY LIFE EDUCATION & CAREER

Where did you grow up? ____

How long have you lived in Atlanta? ____

High School/GED ___ College Degree___ Graduate Degree (or Higher)___ Vocational Degree___

Name of College, University and/or Vocational School: ____________________________________

Type of degree: ______________________________ Major: ______________________________

What is your current employment status/job title? ____

Current level of satisfaction with your employment situation: Poor 1 2 3 4 5 6 7 Excellent

Any past career positions that you feel are relevant: ______________________________________

____

What do you consider to be your greatest strengths?

____

____

____

Additional information you would like to include: ____

____

____

____

PLEASE CHECK ALL THAT APPLY & CIRCLE YOUR MAIN CONCERN(S):

Difficulty with	Now	Past		Difficulty with	Now	Past		Difficulty with	Now	Past
Anxiety				People in General				Abdominal Distress		
Depression				Parents				Fainting		
Anger or Temper				Children				Dizziness		
Panic				Marriage/Partnership				Diarrhea		
Fears				Friend(s)				Shortness of Breath		
Irritability				Co-Worker(s)				Chest Pain		
Concentration				Employer				Lump in Throat		
Headaches				Finances				Sweating		
Memory Loss				Legal Problems				Heart Palpitations		
Excessive Worry				Sexual Concerns				Muscle Tension		
Trusting Others				Hx of Child Abuse				Pain in Joints		
Communication				Hx of Sexual Abuse				Allergies		
Drugs				Domestic Violence				Making Careless Mistakes		
Alcohol				Thoughts of Self Harm				Frequent Fidgeting		
Caffeine				Thoughts of Hurting Others				Speaking without Thinking		
Frequent Vomiting				Self Harm				Patience		
Eating Problems				Thoughts of Suicide				Paying Attention		
Severe Weight Gain				Sleeping too much				Easily Distracted		
Severe Weight Loss				Sleeping too little				Hyperactivity		
Blackouts				Getting sleep				Chills or Hot Flashes		
Feeling Manic				Waking too early				Completing Tasks		
Head Injury				Nightmares				Nausea		

Family History of (check all that apply):
Drug/Alcohol Problems ___ Physical Abuse ___ Depression ___ Legal Trouble ___ Anxiety ___

Sexual Abuse ___ Domestic Violence ___ Hyperactivity ___ Psychiatric Hospitalization ___

Suicide ___ Learning Disabilities ___ "Nervous Breakdown" ___