



Confidential Client Information

Name: _____ Date _____
Address: _____ Date of Birth/Age _____
City, State, Zip: _____ Social Security Number _____
Policyholder Name: _____ Home Telephone # _____
Insurance Carrier _____ Cell/Work Telephone # _____
Policyholder DOB: _____ Policy/Group #/ _____
Policyholder SS#: _____
Phone Number to Verify Benefits: _____
Address to Mail Claims: _____
Employer's Name and Address: _____
Current Marital Status: _____ Date Married: _____ Age at Marriage: _____
Dates of any previous marriages: _____
Name, Age, & Sex of Children (include those of your spouse, those from previous marriages, and any deceased): _____

Highest Educational Level attained: _____
Civic or Social Activities or Concerns: _____
Are you under a doctor's care for any physical condition? _____
If so, Name and Phone Number of Doctor: _____
May I contact your Doctor to Coordinate Care if Necessary Yes [] No []

440 S. Perry Street, # 7, Lawrenceville, Georgia 30046
1755 N. Brown Road, Suite 200, Lawrenceville, Georgia 30043
160 Clairemont Avenue, Suite 200, Decatur, Georgia 30030
Ph: 678-205-0877
Fax: 678-205-0800
www.drmconsultingservices.com

If Yes, Please Sign Here for Authorization _____

List any major illnesses and injuries you have had in the past: _____

List any medications you take: _____

List any surgeries or hospitalizations you have had in the past: _____

List any allergies to any medications: _____

Do you smoke? Yes/No If yes, how many packs per day? _____

Do you drink alcohol? Yes/No If yes, how many glasses per day? _____

Do you use other drugs Yes/No If yes, What? How frequent? _____

Previous counseling or therapeutic help: _____

From whom? _____ Dates: _____

Was counseling beneficial? _____ Why or Why not? _____

BRIEFLY STATE WHY YOU ARE SEEKING THERAPY AND YOUR GOALS FOR THERAPY: _____

How long has this situation been in existence?

Please circle all of the following that apply:

Abuse/ Neglect	Family Conflict	Panic	Stress
Anger	Financial Difficulties	Parenting Difficulties	Suicidal Thoughts
Anxiety/Nervousness/Fears	Health Problems	Promiscuity	Tiredness
Career/Work Difficulties	Irritability	Psychosis	Trauma History
Concentration Difficulties	Legal Issues	Poor Self Control	Weight Loss/Gain
Depression	Loneliness	Relationship Issues	Alcohol/Drugs
Divorce/Separation	Low Self Esteem	Sexual Problems/Sexuality Issues	Other
Eating Problems/Disorder	Memory Difficulties	Shyness	

Domestic Violence	Nightmares	Social Skills Deficits	

In case of emergency, contact: _____ Phone _____

Relationship _____

Referred by: _____

May we send this person/agency a letter thanking them for their referral to our agency?

Yes No

May we send you information about our upcoming activities and events by mail or email?

Yes No

We make reminder calls on the day before appointments. Would you like to receive a reminder of your appointment to your Home Phone Cell Phone Email ?

Signature _____ Date _____