DRM Consulting Services Inc.
Dea Rabon Montgomery, Ph.D. Licensed Psychologist

Confidential Client Information

_____
Date

Name:_____ _____
Date of Birth/Age

Address:_____ _____
Social Security Number

_____
City, State, Zip:_____ Home Telephone #

_____
Cell/Work Telephone #

Policyholder Name:_____ _____
Email Address

Insurance Carrier _____ Policy/Group #/_____

Policyholder DOB:_____ 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_____