Divine Intervention Counseling & Consulting Group
501 Pulliam St suite 545
Atlanta, Ga. 30312
404-524-9174

Client Information Form

Today's date: _____

Your name: _____
Last **First** **Middle Initial**

Date of birth: _____ **Social Security #:** _____

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: _____
- May I have your permission to thank this person for the referral?
  ☐ **Yes** ☐ **No**
- If referred by another clinician, would you like for us to communicate with one another?
  ☐ **Yes** ☐ **No**

Person(s) to notify in case of any emergency: _____
Name **Phone**
I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

Please briefly describe your presenting concern(s): _____
_____
_____
What are your goals for therapy? _____
_____
_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _____
_____
_____

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses: _____

_____

_____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

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/week/month/year? ____

Do you use any non-prescription drugs? (Please remember that this form is completely confidential).

☐ YES ☐ NO If YES, what kinds and how often? _____

_____

Previous Hospitalizations: (Approximate dates and reasons):_____

_____

_____

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? No

(Please list approximate dates and reasons): _____

_____

_____

FAMILY:

How would you describe your relationship with your mother? _____

_____

_____

How would you describe your relationship with your father? _____

_____

_____

Are you parent's still married or did they divorce?_____ If they divorced, how old were you when they separated or divorced, and how did this impact you? _____

_____

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: _____

_____

_____

How many sisters do you have? _____ Ages? _____

How many brothers do you have? _____ Ages? _____

How would you describe your relationships with your siblings? _____

_____

_____

RELATIONSHIP STATUS:

Currently in Relationship? No How Long? ____ Relationship Satisfaction: 1 = Poor

Married/Life Partnered? No How Long? _____ Previously Married/Life Partnered? No

If so, length of previous marriages/committed partnerships_____

Do you have children? No If YES, how many and what are their ages:_____

Describe any problems any of your children are having: _____

PLEASE CHECK ALL THAT APPLY & *CIRCLE* THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Anxiety →	☐	☐	People in General →	☐	☐	Nausea →	☐	☐
Depression	☐	☐	Parents	☐	☐	Abdominal Distress	☐	☐
Mood Changes	☐	☐	Children	☐	☐	Fainting	☐	☐
Anger or Temper	☐	☐	Marriage/Partnership	☐	☐	Dizziness	☐	☐
Panic	☐	☐	Friend(s)	☐	☐	Diarrhea	☐	☐
Fears	☐	☐	Co-Worker(s)	☐	☐	Shortness of Breath	☐	☐
Irritability	☐	☐	Employer	☐	☐	Chest Pain	☐	☐
Concentration	☐	☐	Finances	☐	☐	Lump in the Throat	☐	☐
Headaches	☐	☐	Legal Problems	☐	☐	Sweating	☐	☐
Loss of Memory	☐	☐	Sexual Problems	☐	☐	Heart Palpitations	☐	☐
Excessive Worry	☐	☐	History of Child Abuse	☐	☐	Muscle Tension	☐	☐
Feeling Manic	☐	☐	History of Sexual Abuse	☐	☐	Pain in joints	☐	☐
Trusting Others	☐	☐	Domestic Violence	☐	☐	Allergies	☐	☐
Communicating with Others	☐	☐	Thoughts of Hurting Someone Else	☐	☐	Often Make Careless Mistakes	☐	☐
Drugs	☐	☐	Hurting Self	☐	☐	Fidget Frequently	☐	☐
Alcohol	☐	☐	Thoughts of Suicide	☐	☐	Speak Without Thinking	☐	☐
Caffeine	☐	☐	Sleeping Too Much	☐	☐	Waiting Your Turn	☐	☐
Frequent Vomiting	☐	☐	Sleeping Too Little	☐	☐	Completing Tasks	☐	☐
Eating Problems	☐	☐	Getting to Sleep	☐	☐	Paying Attention	☐	☐
Severe Weight Gain	☐	☐	Waking Too Early	☐	☐	Easily Distracted by Noises	☐	☐
Severe Weight Loss	☐	☐	Nightmares	☐	☐	Hyperactivity	☐	☐
Blackouts	☐	☐	Head Injury	☐	☐	Chills or Hot Flashes	☐	☐

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems ☐	Physical Abuse ☐	Depression ☐	
Legal Trouble ☐	Sexual Abuse ☐	Anxiety ☐	
Domestic Violence ☐	Hyperactivity ☐	Psychiatric Hospitalization ☐	
Suicide ☐	Learning Disabilities ☐	"Nervous Breakdown" ☐	

Any additional information you would like to include:

_____

_____

_____

_____

Clear Form