Cherokee Center for Change Counseling, Inc.

409 Old Boring Lane, Woodstock, GA 30189
770-928-7300

Client Information Form

This form is completely confidential

Today's date: _____

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

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

Home street address: _____

City: _____ **State:** _____ **Zip:** _____

Name of Employer: _____

Address of Employer: _____

City: _____ **State:** _____ **Zip:** _____

Primary Phone: □_____ **Work Phone:** □_____

Secondary Phone: □_____ **Email:** _____

Please check the box next to the numbers that are acceptable for us to contact you and/or leave a message.

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 **Primary Phone** **Secondary Phone**

_____
Name **Primary Phone** **Secondary Phone**

I will only contact these people 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)? _____

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

MEDICAL HISTORY:

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

Current Medications (if you need more room, please write on the back of this page):

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? 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 because of your substance use? YES NO
Previous medical hospitalizations (Approximate dates and reasons):
_____
_____
_____
Previous psychiatric hospitalizations (Approximate dates and reasons):
_____
_____
_____
Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO
(Please list approximate dates and reasons):
_____
_____
_____
Age_____ Gender _____

EDUCATION & CAREER

Education level:
High School/GED ___ College Degree ___ Graduate Degree (or Higher) ___ Vocational Degree ___

Current employer: _____
Position: _____ POOR EXCELLENT
Employment Satisfaction: 1 2 3 4 5 6 7

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

Difficulty with:	Now	Past		Difficulty with:	Now	Past		Difficulty with:	Now	Past
Anxiety →				People in general →				Nausea→		
Depression				Parents				Stomach aches		
Mood changes				Children				Fainting		
Anger/Temper				Marriage/Partnership				Dizziness		
Panic				Friends				Diarrhea		
Fears				Co-workers				Shortness of breath		
Irritability				Employer				Chest pain		
Concentration				Finances				Lump in throat		
Headaches				Legal problems				Sweating		
Loss of memory				Sexual concerns				Heart problems		
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 makes careless mistakes		
Drugs				Hurting self				Fidgets 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		
Black outs				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"	

If you checked any "family history", please explain your relationship to the person or people:

_____

_____

_____

Any additional information you would like to include:

_____

_____

_____

_____