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 child's name: ____
First Middle Initial Last

Parent or Legal Guardian's Name: ____
First Middle Initial Last

____
First Middle Initial Last

Child's date of birth: ___________________________ **Gender:** ________________

Parent or Legal Guardian's Social Security #: ____

Home street address: ____

City: ____ **State:** ___________ **Zip:**________________________

Parent or Legal Guardian's 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 child's presenting concern(s):

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____

What are your/your child's goals for therapy?

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____

How long do you expect your child 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 your child has had:

____
____
____

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

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Previous medical hospitalizations (Approximate dates and reasons): ________________________________
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____

Previous psychiatric hospitalizations (Approximate dates and reasons): ______________________________
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Has your child ever talked with a psychiatrist, psychologist, or other mental health professional? (If yes, please list approximate dates and reasons):

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

Difficulty with:	Now	Past		Difficulty with:	Now	Past		Difficulty with:	Now	Past
Anxiety →				Tantrums →				Nausea→		
Depression				Parents divorced				Stomach aches		
Mood changes				Seizures				Fainting		
Anger/Temper				Cries easily				Dizziness		
Panic				Problems with friends				Diarrhea		
Fears				Problems in school				Shortness of breath		
Irritability				Fear of strangers				Chest pain		
Concentration				Fighting with siblings				Lump in throat		
Headaches				Issues related to divorce				Sweating		
Loss of memory				Sexually acting out				Heart problems		
Excessive worry				History of child abuse				Muscle tension		
Wetting the bed				History of sexual abuse				Bruise easily		
Trusting others				Domestic violence				Allergies		
Communicating with others				Thoughts of hurting someone else				Often makes careless mistakes		
Separation anxiety				Hurting self				Fidgets frequently		
Alcohol/Drugs				Thoughts of suicide				Impulsive		
Drinks caffeine				Sleeping too much				Waiting his/her 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		
Head injury				Sleeping alone				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 child's relationship to the person or people:

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Any additional information you would like to include:

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