Anxiety Tamer Counseling Services
10475 Medlock Bridge Rd., Bldg. 200, Suite 205, Johns Creek, GA 30097
678.474.4899 phone 678.688.4027 fax

Date_____

CLIENT INFORMATION

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

Name_____Date of Birth_____Age_____Sex_____

Address _____
Number Street

_____
City State Zip Code

Race/Ethnic Group: _____Social Security #: _____

Home Phone: _____Work Phone: _____Cell Phone: _____

If Necessary, May I Call You At Home? **Y N** Any Special Instructions? _____

If Necessary, May I Call You At Work? **Y N** Any Special Instructions? _____

If Necessary, May I Call Your Cell Phone: **Y N** Any Special Instructions? _____

If Necessary, May I E-Mail You? **Y N** Any Special Instructions? _____
E-Mail Address: _____*****Please be aware that email might not be confidential *****

May I Send Mail To You? **Y N** Any Special Instructions? _____

May I Contact You In The Future To Tell You About Upcoming Services, Special Deals, New Products or Newsletters? **Y N**
Any Special Instructions? _____

*Please Indicate Who Should Be Contacted In Case of An Emergency: (names and phone numbers):

_____

_____

*completion of this section indicates permission to contact these people should an emergency (as determined by the therapist) arise. If you choose not to complete this section, should an emergency arise, I will contact 911.

How Did You Hear About Me? Facebook/Twitter NetworkTherapy PsychologyToday Google Search
Anxiety & Depression Assoc. of America Website Other_____

If A Specific Person Referred You, Who Was It? _____
May I Send This Person A Thank You Note For The Referral? YES NO

Education & Degree (If Applicable) _____

Occupation:_____ Employer/Company Name: _____

Current Level of Satisfaction with Place of Employment: Poor Excellent
1 2 3 4 5 6 7 8 9 10

Presently Living with: _____Parents _____Spouse _____Roommate _____Alone/Other _____

Relationship Status: MARRIED SINGLE DIVORCED SEPARATED WIDOWED DATING _____#yrs

Level Of Satisfaction With This Status: Poor Excellent
1 2 3 4 5 6 7 8 9 10

Spouse/Significant Other's Name _____ Age_____

Any Relevant Information About Him/Her: _____

Children: **Y N** **If Yes**, # of children _____ Ages: _____

FAMILY HISTORY

Please List Family Members' Names, Ages, & Relevant Information:

*Mother: Name: _____
Living_____ Deceased _____ Year & Cause of Death: _____

Describe your relationship with your Mother: _____

*Father: Name: _____
Living _____ Deceased _____ Year & Cause of Death: _____

Describe your relationship with your Father: _____

Are your parents still married to each other? **Y N** If divorced, how old were you? _____

Describe how this impacted you: _____

*Sisters: How many? _____ Ages: _____

Describe your relationship with your sisters: _____
_____
_____

*Brothers: How many? _____ Ages: _____

Describe your relationship with your brothers: _____
_____
_____

* Any Other Important Family Members (Aunts, Uncles, Step- Family Members): _____
Describe the person's impact on your life: _____
_____

Please indicate any psychological difficulties experienced by other members of your family:

	Father	Mother	Sisters	Brothers	Aunts	Uncles	Grandparents	Children
Panic Attacks								
Anxiety								
Phobias								
OCD								
Bipolar								
Depression								
Schizophrenia								
Alcohol/Drugs								
Eating D/O								
Trauma History								
Suicide								
Physical Abuse								
Sexual Abuse								
ADHD / ADD								

Other: _____

Please list any significant life events that occurred in your childhood: _____

_____

Describe your current coping mechanisms and self-care: _____

What do you consider your strengths? _____

What are your hobbies? _____

Current level of satisfaction with friends and overall support system: Poor 1 2 3 4 5 6 7 8 9 10 Excellent

MEDICAL HISTORY/INFORMATION

Date of last Physical Exam: _____ Outcome: _____Height:_____ Weight:_____

Please List All Medical Diagnoses/Conditions That You have: _____
_____

Please List **All Medications**

Medication	Dosage (amount & times/day)	Prescribing Doctor	Reason

Significant Illnesses/Surgeries/Medical Hospitalizations:
Approximate Dates & Reasons: _____

Do You Smoke/Use Tobacco? Y N If YES, How Much Per Day? _____

Do You Consume Caffeine? Y N If YES, How Much Per Day? _____

Do You Drink Alcohol? Y N If YES, How Much Per Week? _____

Do You Use Any Non Prescription Drugs? Y N
If Yes, What Kinds & How Often _____

Have Any Of Your Friends or Family Members Voiced Concern About Your Substance Use? Y N

Have You Ever Been In Trouble Or In Risky Situations Because Of Your Substance Use? Y N

Have You Ever Been Hospitalized For A Psychiatric Reason? **Y N** If **Yes**, **When, Where, How Long & Reason**
_____

_____

Have you had any recent changes in your eating habits? If so, please describe: _____
Recent Increased Appetite: _____ Recent Decreased Appetite: _____

Describe your sleeping habits: Approximate # of Hours of Sleep: _____ Difficulty getting to sleep: ____ / Staying Asleep:_____

Do you exercise? Y N If yes, what activities do you do for exercise & how often? _____
_____

Describe your religious/spiritual background _____

Is your faith/spirituality important in your life now? If so, please explain_____

Do you want to include your faith/spirituality into our sessions? If so, how? _____

PRESENTING PROBLEM

Briefly Describe What Brings You In For Counseling: _____

_____

How long have you been experiencing your concerns?

_____

Have you ever seen a psychologist, psychiatrist, or counselor before?

Dates	Names	Reasons	Outcome
_____	_____	_____	_____
_____	_____	_____	_____

Check The Items In The Following List That Are Areas Of Concern & **CIRCLE The Main Problem**:

Pain	Drug Use	Legal Issues	Hyperventilation	Thoughts of Harming Others
Panic	Marriage	Nightmares	Recent Accidents	Family Alcohol/Drug Use
Shaky	Phobias	Skin Picking	Appetite Change	Recent Hospitalizations
Fears	Shyness	Self-Esteem	Spiritual Issues	Avoidance of Situations
Work	Isolation	Alcohol Use	Lack of Interest	Shortness of Breath
Nausea	Finances	Job Changes	Hearing Voices	Social Relationships
Stress	Trauma	Nervousness	Tense Muscles	Self-Harm Thoughts
Anger	Perspiring	Insomnia	Physical Abuse	Intrusive Thoughts
Sleep	Depression	Irritability	Recent Deaths	Separation/Divorce
Fatigue	Chest Pain	Hopelessness	Sexual Concerns	Compulsive Habits
Fainting	Dizziness	Recent Moves	Procrastination	Suicidal Thoughts
Paranoia	Motivation	Stomach Pain	Perfectionism	Making Decisions
Crying	Impatience	Racing Heart	Anxiety	Suicide Attempts
Family	Palpitations	Excessive Worry	Low/High Energy	

Describe any major changes or sources of stress in your life in the past two years: _____

_____

Please add any additional information you feel would be useful: _____

_____

_____

GOALS/PURPOSE OF COUNSELING

What Are Your Goals For Therapy / How Would Your Life Be Different From What It Is Now? _____

_____

_____

_____

How Long Do You Expect To Be In Therapy To Accomplish These Goals (or at least feel like you have the tools to accomplish them on your own?) _____

_____

Signature: _____ Date:_____

(Information Given is True and Complete)