TRANSFORMATIONS
THERAPY OF ATLANTA

Client Intake Form

Please complete and submit prior to your initial appointment, if possible

Name: _____
(First and Last)

Name of Parent/Guardian: (For children 17 and younger)

_____

Date of Birth: _____ Marital Status: ___Single ____ Married ____Divorced ___Widowed

Address: _____

Contact Number: _____

Alternate Contact Number:_____

Email Address: _____

Referral Source: _____

Emergency Contact: (Name and Number) _____

Briefly describe why you are seeking counseling: _____
_____
_____
_____
_____
_____
_____
_____

When did these problems begin? _____
_____
_____
_____

Have you ever had counseling before? If so, give dates, reasons for counseling and outcome: ___
_____
_____
_____
_____
_____

Have you ever been hospitalized in a psychiatric facility? If so, give dates and reason for admission: _

Have you ever had suicidal thoughts, plans or attempts? If so, give dates of last thought/plan and list all attempts: _____

Have you ever had incidents of self harm (cutting, scratching, burning, hair pulling, hitting, etc.)? If so, please explain:_____

Do you have any family history of mental illness (maternal or paternal)? If so, please list and specify: _

Do you have any diagnosed mental health or medical conditions? If so, please list all diagnosis and list any prescribed medications. _____

Please provide the name and contact number for your Primary Care Physician and/or Psychiatrist: ____

Do you feel you have an adequate support system? If so, please discuss who is in this system: _____

Have you experienced any trauma (abuse, major life changes, divorces, break ups, etc.) If so, please explain: _____

Where are you employed?_____ How long? _____

What are your hobbies or any organizations in which you are involved? _____

What are your self care strategies/ habits? _____

Do you have any current and/or history of substance abuse (alcohol, recreational drugs)? If so, please list amount and frequency: _____

Do you have any unresolved issues from childhood that could be affecting your presenting issues? If so, please specify: _____

Discuss your desired treatment goals/outcomes: _____

What is your schedule availability? Desired appointment days/times: _____