Counseling Innovations
Behavioral Health & Wellness Center
130 Vann Street NE, Ste. 220 • Marietta, GA 30060

NEW CLIENT INFORMATION

Client's Name _____ Date of Birth _____

Address _____ Client's SS# _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Employer _____ Job Title _____

Student / Current School _____ Highest Level of Education _____

❒ Married ❒ Divorced ❒ Single ❒ Remarried ❒ Other

Spouse's Name _____ (❒ 1st ❒ 2nd Marriage)

Spouse's Address _____ Home Phone _____

Spouse's Employer _____ Work Phone _____

People Living In Your Home Please Provide name(s) & ages

_____

_____

IF CLIENT IS A MINOR OR LEGAL DEPENDANT

Parent / Guardian Name(s) _____

Address _____ City, State, Zip _____

Home Phone _____ Work Phone _____

NEAREST RELATIVE IN CASE OF EMERGENCY

Name _____

Address _____ City, State, Zip _____

Home Phone _____ Work Phone _____

Referred By _____

Previous Counseling:

❒ Yes ❒ No Clinician's Name _____

Issues Addressed _____

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INDIVIDUAL HISTORY

❑ Physical Abuse ❑ Sexual Abuse ❑ Domestic Violence
❑ Rape ❑ Arrests ❑ Hospitalization

PHYSICAL HEALTH / SYMPTOMS

❑ Stomach Ache ❑ Head Ache ❑ Vomiting ❑ Shortness of Breath
❑ Sweaty Palms ❑ Diarrhea ❑ Dizziness
❑ Blurred Vision ❑ Chest Pain ❑ Nausea

FUNCTION / ACTIVITY

❑ Lying ❑ Obsessive Behavior ❑ Academic / Work Inhibition
❑ Stealing ❑ Racing Thoughts ❑ Loss of Interest or Pleasure
❑ Gambling ❑ Fatigue ❑ Little / No Sleep
❑ Excessive Worry ❑ Weight Loss ❑ Nightmares
❑ Self Injury ❑ Weight Gain ❑ Substance Use / Abuse
❑ Alcohol ❑ Drugs
❑ Other _____

EMOTIONAL SYMPTOMS

❑ Anger ❑ Indecisive ❑ Helplessness
❑ Irritability ❑ Anxiety ❑ Hopelessness
❑ Sadness ❑ Panic ❑ Suicidal Thoughts
❑ Tearful ❑ Fearful ❑ Other _____

DURATION OF SYMPTOMS _____

CURRENT MEDICATIONS

Medication	Strength	How Often	Prescribed By	Date

PAST MEDICATIONS (if applicable)

_____

MY THREE LARGEST AREAS OF CONCERN ARE:

1. _____
2. _____
3. _____

FOR OFFICE USE ONLY

❑ Axis I _____
❑ Axis II _____
❑ Axis III _____
❑ Axis IV _____
❑ Axis V _____

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CLIENT COMMUNICATION

Counseling Innovations may need to contact you to schedule and / or reschedule appointments, to schedule follow-up visits and other such administrative issues. To ensure that your privacy is maintained to the fullest extent possible, please select the method by which Counseling Innovations may contact you.

Home phone _____
Leave a message? ❑ Yes ❑ No

Mobile phone _____
Leave a message? ❑ Yes ❑ No

Personal Email _____

Work Phone _____
Leave a Message? ❑ Yes ❑ No

Work Email _____

CLIENT AGREEMENT

By signing below you have indicated that you have been given the opportunity to review or obtain a copy of the HIPPA Notice and the Limits To Confidentiality, and that it is your responsibility to ask any questions. Your signature and date also indicate that you have read the Treatment Agreement and Financial Agreement, and agree to abide by the terms of these agreements throughout the duration of your professional relationship with Counseling Innovations.

Print Name _____

Signature _____ Date _____

Witness Name _____

Witness Signature _____ Date _____