

TRILLIUM SPRINGS COUNSELING

1640 Powers Ferry Road, Building 16, Suite 100, Atlanta, Georgia 30067

CLIENT INFORMATION FORM

Today's date: _____

Your name: _____
Last First Middle Initial

Date of birth: _____ Social Security #: _____

Home street address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Best phone for reaching you or leaving discreet messages. Please indicate any restrictions.

Education: _____ Highest Degree Obtained: _____

Occupation: _____

Name of Employer: _____ Phone: _____

Spiritual Resources: _____ Religious Affiliation: _____

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 Phone

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

Briefly describe your concern(s) which prompted you to seek counseling at this time:

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)? _____

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

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Anxiety →			People in General →			Nausea →		
Depression			Parents			Abdominal Distress		
Mood Changes			Children			Fainting		
Anger or Temper			Marriage/Partnership			Dizziness		
Panic			Friend(s)			Diarrhea		
Fears			Co-Worker(s)			Shortness of Breath		
Irritability			Employer			Chest Pain		
Concentration			Finances			Lump in the Throat		
Headaches			Legal Problems			Sweating		
Loss of Memory			Sexual Problems			Heart Palpitations		
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 Make Careless Mistakes		
Drugs			Hurting Self			Fidget 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		
Blackouts			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”		

Any additional information you would like to include:
