TRILLIUM SPRINGS COUNSELING
1640 Powers Ferry Road, Building 16, Suite 300, Atlanta, Georgia 30067

Client Information Form

Today's date: _______________

Your child's name: ____
Last First Middle Initial

Parent or Legal Guardian's Name: ____________________________________
(Responsible for Payment) Last First Middle Initial

Child's date of birth: _______________

Parent or Legal Guardian's Social Security Number: __________________________

Home street address: ____

City: ______________________________ **State:** _______**Zip:** ____________

Parent or Legal Guardian's Name of Employer: ____________________________

Address of Employer: ____

City: ______________________________ **State:** _______**Zip:** ____________

Home Phone: ____________________ **Work Phone:** ______________________
Cell Phone: __________________ **Email:** ____________________________
Calls will be discreet, but please indicate any restrictions: ____________________
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School where child is enrolled: ______________________________ **Grade:** __________

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): ______________________________

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 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: ______________

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Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Previous 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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FAMILY:

How would you describe your child's relationship with his or her mother? ______________________________

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How would you describe your child's relationship with his or her father? ______________________________

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Are the child's parents still married or did they divorce?________________ If they divorced, how old was the child when the parents separated or divorced, and how do you think this impacted him or her? ___________

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Please describe your child's relationship with his or her grandparents: ______________________________

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Were there any other primary care givers who have had a significant relationship with your child? If so, please describe how this person may have impacted your child's life: ______________________________

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	Name	Age	Describe Relationship
Brother(s)	____________	____	____________
	____________	____	____________
	____________	____	____________
Sisters(s)	____________	____	____________
	____________	____	____________
	____________	____	____________

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 or Temper			Cries Frequently			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 the Throat		
Headaches			Issues Re: 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			Bruises 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”	

Any additional information you would like to include: ______________________________

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